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THE UNIVERSITY OF ALBERTA
THE FEDERAL ROLE IN FINANCING
PROVINCIAL HEALTH PROGRAMS

by


 GORDON R. McLEOD

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
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DEPARTMENT OF COMMUNITY MEDICINE

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The undersigned certify that they have read,
and recommend to the Faculty of Graduate Studies and
Reserach, for acceptance, a thesis entitled THE FEDERAL
ROLE IN FINANCING PROVINCIAL HEALTH PROGRAMS submitted
by Gordon R. McLeod in partial fulfilment of the re-
quirements for the degree of Master of Health Services
Administration.

DEDICATION

To my wife Sharon, who is such
a special person.

To my Mother, whose love, guidance
and wisdom will never be forgotten.

To Shawn and Nathan, two wonderful
children.

ABSTRACT

The role of the federal government in financing provincial health programs is currently under review. At the present time, (1976), there is a federal proposal on the table that would radically alter the future federal role, but the provinces have not yet found it acceptable. The purpose of this thesis is to examine the federal government's present role in financing provincial health programs and to determine what this role should be in the future.

The main conclusion of the thesis is that the federal government does have a legitimate role in financing and influencing health programs that are under provincial jurisdiction. This conclusion is supported on economic, political and social grounds. It is also concluded that the most appropriate fiscal transfer mechanism for the federal government to use in the fulfillment of this role is the shared-cost conditional grant. One other conclusion of note is that the current shared-cost conditional grants are not designed in a manner to effectively contribute to cost control.

The major recommendations of the thesis are that:

- 1) The federal government reconsider its latest proposal for financing provincial health programs and develop, in consultation with the provinces, a proposal that recognizes

and thus allows it to fulfill its legitimate role in financing these programs;

2) The federal government support research that would allow it to determine:

- a) what provincial health programs have external benefits, and the magnitude of these benefits;
- b) what provincial health programs are in the "national interest";
- c) what is the most appropriate method of introducing, monitoring and revising programs that the federal government develops; and,
- d) what the most appropriate mechanisms to induce cost restraint in the health field are, and how these mechanisms can be incorporated into any federal conditional grant program.

It was recognized that the recommendations of the thesis would take considerable time to complete and thus proposals that could help alleviate some of the problems with the current conditional grants were suggested.

These were:

- 1) All residential and diagnostic care should be incorporated under one Act and that the Act should reflect the different levels of

care;

- 2) The financing of residential care and diagnostic procedures should be structured to reinforce the utilization of the least cost program;
- 3) The Medical Care Act should be broadened to include other appropriate professionals;
- 4) The total federal participation in financing provincial health programs should have an absolute limit; and,
- 5) The introduction of funding for innovative projects that attempt to provide service of an acceptable quality but at a reduced cost.

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CHAPTER 1

INTRODUCTION

I - PREAMBLE

"Federal-provincial fiscal relations is one of the problems that is rarely quiescent in Canadian politics. Controversies between the two jurisdictions over revenue from subsidies, the division of taxation, and the introduction and funding of programs in many different fields including education, social and welfare services, and income security have been persistent, vexatious, and often acrimonious throughout the entire history of Confederation. The decades following the Second World War have been different only in that they have been characterized by an intensification of the conflicts and complexities in this basic, and perhaps most important aspect of Federalism."¹

The financing of health care has always been problematic, if for no other reason than the fact that it necessitates a somewhat painful allocation of an individual's finite resources. More recently the realization -- or belief -- that health care expenditures have a social, as well as an individual benefit, has stimulated the state to become increasingly involved in financing health care programs.² Thus, the problem

¹P.W. Fox, ed., *Politics: Canada* (3rd ed.; Toronto: McGraw-Hill Company of Canada Limited, 1970), p.114.

²Although there is not very reliable data to support the assumption that there are significant social returns from health investment, there is a strong belief that they exist. As an example of this belief, see E.J. Hanson, The Public Finance Aspects of Health Services in Canada (Ottawa: Queen's Printer, 1963), pp.4-5.

is no longer just the question of total expenditures on health care, but has taken on the added dimension of determining the trade-off between individual and government financing.

While the difficulty in determining the trade-off between individual and government financing is more or less of a problem in financing health care in any country, Canada, because of its federal form of government, faces unique problems.¹ First, any decision regarding the financing of health care must be made within the framework of a constitution that allocates the major legislative responsibilities to the provincial area. However, the principle fiscal resources to support programs of any magnitude are allocated to the federal sphere. Second, the provinces have differing abilities to support governmental expenditure, including expenditures on health care programs. Third, the views of the federal and provincial governments differ regarding expenditure priorities, both within health programs and between health and other forms of expenditure.

At the present time (1976), the federal

¹The three problems of finance in a federal state closely follows the categorization utilized in J.H. Lynn's Federal-Provincial Fiscal Relations, in Canadian Federalism: Myth or Reality, edited by J.P. Meekison (1st ed.: Toronto: Methuen Publications, 1968), pp. 195-215.

and provincial governments are involved in negotiations to alter both the method and the magnitude of federal contributions in support of provincial health programs. Although the federal proposals to date have been of a conditional grant nature, no agreement has been reached; and some provinces have pressed for other alternatives.

While the outcome of the negotiations is indeterminate, it seems apparent that a change in the federal role in financing provincial health will take place.

II - PURPOSE

The purpose of this thesis is to examine the federal government's present role in financing provincial health programs and to subsequently determine what this role should be in the future. In this regard, attention will be focused on the problems of public finance in a federal state, the current federal involvement in financing provincial health programs, the rationale supporting federal involvement, and the problems that are associated with this form of financial support. Alternative methods of federal participation in financing provincial health programs will also be examined. An attempt will also be made to suggest the most appropriate fiscal transfer mechanism for transferring funds from the federal to the provincial jurisdictions. Also, recommendations related to future federal government actions regarding its role

in financing provincial health programs will be enumerated.

III - RATIONALE

It appears that the financing of provincial health programs in Canada is at the crossroads and that the result of the current negotiations could be a discontinuation of conditional health grant funding.¹

But, while this is a possible outcome, it has been argued that conditional health grant funding has contributed in a positive manner to Canada's provincial health programs.² If this is the case, any change in the method of federal participation should be examined to ensure that we do not enter into a system of finance that is more dysfunctional than the current conditional grant agreements. It follows that this examination should be from a broad political, social and economic perspective.

¹This is the substance of the News Release of the Department of National Health and Welfare, May 8, 1973. To the author's knowledge, the basic position of the participants has not changed. As an example, see "Provinces Reject Health Care Plan," Edmonton Journal, September 26, 1974, p. 18.

²One of the better examples of the argument in favour of conditional health grant funding is P.E. Trudeau, Federal Provincial Grants and the Spending Power of Parliament (Ottawa: Government of Canada, 1969) pp. 20-30.

IV - SCOPE AND LIMITATIONS

This study of the federal government's role in financing provincial health programs is essentially a micro study of one aspect of Canadian social policy. In this regard, two important assumptions are reflected in this study. The first assumption is that, while the federal involvement in financing provincial health programs is the topic under consideration, it is only one component of the issue of public finance in a federal structure. The second assumption is that, while the federal government is involved in financing provincial health programs, the purpose of this involvement encompasses a combination of economic, political and social objectives. Thus, while the purpose of this study is to examine the federal financial involvement in support of provincial health programs, it is carried out within the framework of public finance and the complex inter-relationships that exist among the economic, political and social objectives.

There are, of course, many federal financial programs that finance provincial health programs if health is defined in a broad manner. In fact, very few federal expenditures at the provincial level cannot, at least tangentially, be related to health care. This study is restricted to the traditional health care programs

that are of an ongoing nature.¹ For the purpose of this study, a traditional health care program is defined as medical, nursing, and other para-medical services and the health care organizations and institutions where these services are offered as the primary component of care.²

The study specifically excludes health care programs for the native population and research projects that have a health care program component, but are terminally funded.

¹This specifically excludes those legislative responsibilities for health care that are specifically assigned to the federal government under Section 91 (7, 11, 24, 25 and 28) of the British North American Act (See Appendix 1).

²There are two points that must be noted in regard to this statement. First, although the definition of a health care program may seem somewhat incongruous in that medical, nursing and other para-medical services are combined with health care organizations and institutions, this is not really so. Any health care program requires both manpower and a site of operation. This has been recognized by the federal government in its financial support of both the manpower component of health care and in its support of health care institutions and organizations. Second, what actually constitutes the break between a health or a social service program is extremely difficult to define. In one sense, all health programs are of a social service nature, and all social service programs have an implied health component; but the definition of health programs used here is health in the usual sense of the word. The specific Acts that support these health programs are enumerated in the Format.

V - FORMAT

This thesis is divided into eight chapters. Chapter I includes the preamble, purpose, rationale, scope, format and definitions related to the study. Chapter II discusses and reviews the problems associated with financing health care programs in Canada. The discussion in this Chapter is in the framework of the problems of public finance in a federal structure as it specifically relates to the financing of health care programs in Canada. Chapter III outlines and describes the history and current federal involvement in financing health care programs in Canada. The specific current financial programs that form the body of the Chapter are those programs authorized under the Medical Care Act,¹ the Hospital Insurance and Diagnostic Services Act,² the Health Resources Fund Act,³ the Canada Assistance Plan Act,⁴ and the Vocational Rehabilitation of Disabled

¹Canada. Medical Care Act. Assented December 21, 1966 (Ottawa: Queen's Printer, 1966).

²Canada. Hospital Insurance and Diagnostic Services Act. Assented April 12, 1957 (Ottawa: Queen's Printer, 1957).

³Canada. Health Resources Fund Act. Assented July 11, 1966 (Ottawa: Queen's Printer, 1966).

⁴Canada. Canada Assistance Plan Act. Assented July 15, 1966 (Ottawa: Queen's Printer, 1966).

Persons Act.¹ Chapter IV discusses the rationale of federal involvement in financing provincial health programs. In this Chapter, specific comment will be made on the economic, political and social rationale. Chapter V discusses some of the problems associated with the current federal involvement in financing provincial health programs. Chapter VI is a distillation of a number of studies that are related to financing health care in Canada. In this Chapter, particular attention will be on the recommendations that the various studies have made in regard to the federal role in financing provincial health care programs. Chapter VII will examine alternative mechanisms that would allow the federal government to financially support provincial health programs. It will also evaluate the various mechanisms and attempt to determine which is the most appropriate for the future. Finally, Chapter VIII will present a summary of the major points in the thesis, the conclusions that can be drawn on the basis of the thesis, specific recommendations as to the future role of the federal government in the financing of provincial health programs, and recommended avenues for future research applicable to a more objective

¹Canada. Vocational Rehabilitation of Disabled Persons Act. Assented January 21, 1961 (Ottawa: Queen's Printer, 1961).

definition of this role. Chapter VIII will conclude with some specific proposals for the resolution of some of the problems facing conditional health grant funding.

VI - DEFINITIONS

Tax Abatement: refers to the federal government reducing its level of taxation and thus allowing the provincial governments access to a higher level of taxation in that particular field.

Provincial Health Care Program: refers to the traditional medical, nursing and other para-medical services and the health care organizations and institutions where these services are offered as the primary component of care.

Equalization Payment: refers to an unconditional transfer of revenue to the provinces based on the provinces' ability to raise revenue via its own taxation.

Unconditional Grant: refers to any transfer of revenue to the provinces where the federal government does not stipulate how the revenue can be utilized.

Conditional Grant: refers to any transfer of revenue to the provinces where the federal government stipulates how the revenue can be utilized.

Block Grant: refers to a conditional transfer of revenue to the provinces where the federal government stipulates

general guidelines as to how the revenue can be utilized.

Indirect Tax: refers to a tax that can be passed on and not necessarily absorbed by the person on whom it is levied.

Federal State: refers to a state where powers are divided according to the principle that there is a single authority over the whole area in respect to certain matters, and that there are independent regional authorities for other matters, each set of authorities being co-ordinate with, and not subordinate to the other within its own prescribed sphere.

Unitary State: refers to a state where one central government is vested with complete authority over all matters within the state.

Contracting Out: refers to the situation where a conditional grant program exists, but where the province has the discretion to opt for a tax abatement in lieu of the conditional grant payment.

Externality: refers to the divergence between the costs and gains from the standpoint of individual decision makers and those from the standpoint of others. The individual decision maker can be an individual citizen or organized group such as a government.

CHAPTER 2

PROBLEMS OF FINANCING HEALTH

CARE IN CANADA

I - INTRODUCTION

The purpose of this Chapter is to elaborate on the general problems of public finance in a federal state and relate these problems to financing provincial health programs in Canada. A comparison will be drawn with public finance in a unitary system of government, to highlight the problems that are discussed and how they influence inter-governmental public finance in a federal structure.

J.H. Lynn has highlighted three major problems associated with public finance in a federal state.¹ These problems are related to; the allocation of revenue sources and expenditure responsibilities, the unequal tax basis among the regional governments, and the differing perspectives between the central and regional governments. In Canada, the present solution to these problems as they relate to financing health care, consists of a system of tax abatements, equalization payments and

¹As noted in Chapter I, the discussion of the problems of finance in a federal state is an adaptation of, but closely follows, the discussion in J.H. Lynn, "Federal Provincial Relations," in Canadian Federalism: Myth or Reality (1st ed.,) edited by P.J. Meekison, pp. 195-215.

conditional grants.¹

The tax abatements are an attempt to balance the provinces' expenditure responsibilities and revenue resources by increasing their total revenues. This increased revenue can then be used to support expenditures on all government programs at the provincial level, including health programs. The equalization payments are a mechanism to allow the lower-income provinces to support an equitable or nationally acceptable level of services without unduly high taxation relative to the other provinces. The conditional grant also allows the provinces to provide an equitable or nationally acceptable level of services. But it also has a more important function, specifically, it provides the federal government with a mechanism that allows it to stimulate health care and other expenditures according to its perception of national priorities.

Although tax abatements and equalization payments are related to the financial ability that a province has to support health care expenditures, quite clearly the existing conditional grants are seen as the major

¹J.C. Strick, "Conditional Grants and Provincial Government Budgeting," Canadian Public Administration, Vol. 14, No. 2 (Summer 1971), p. 218.

federal support for these expenditures.¹ Recently, this form of federal funding has been the object of considerable concern and debate. On the one hand, the provinces stress that there are a number of serious deficiencies related to the existing conditional grant programs and to the "concept" of conditional grant funding in general.² On the other hand, the federal government, although it sees merit in the concept of conditional grant funding, has voiced concern over the escalating financial responsibility it is incurring under the present conditional grant arrangements.³

¹This does not mean that tax abatements and equalization payments are any less important than conditional grant funding in the overall financing of provincial health programs. Certainly, any province that is receiving large equalization payments is financing its total government services program, including health, on the basis of this type of fiscal transfer, as well as the conditional grants it receives. Also, for the provinces that have a more developed tax base, tax abatements can be a major revenue source.

²Although there have been a number of authors who described various provincial criticisms, particularly good examples are: G.E. Carter, Conditional Grants Since World War II (Toronto: Canadian Tax Foundation, 1971), pp. 70-86; and D.V. Smiley, Conditional Grants and Canadian Federalism (Toronto: Canadian Tax Foundation, 1963), pp. 17-46. For a very political attack on conditional health grant funding, see Charles S. MacNaughton's address to the Federal-Provincial Conference of Ministers of Finance and Provincial Treasurers, November 4-5, 1968. Reproduced in J.P. Meekison Canadian Federalism: Myth or Reality (2nd ed.) pp. 295-298.

³This viewpoint is clearly expressed in a News Release of the Department of National Health and Welfare, May 8, 1973.

II - PROBLEMS OF ALLOCATION OF REVENUE SOURCES AND EXPENDITURE RESPONSIBILITIES

A unitary form of government is characterized by a central decision-making body that has the formal authority to determine the revenue structure of the state and what government expenditures will be supported.¹ Local governments may exist in a unitary state, but they are clearly subordinate to the central government and, in fact, exist at its will. The implication of this type of government structure is that impediments to the central government's decisions on tax structure and expenditure patterns are either minimal or non-existent.

In a federal system of government, the situation is much different. The allocation of revenue sources and expenditures responsibilities are reflected in a

¹It is important to note that although the central government in a unitary state has the formal authority over all aspects of government activity within the state, this does not mean that its freedom to alter the tax structure and/or expenditure patterns is unrestricted. Obviously, local governments, once they have even informal recognition, can influence the decisions of the central government. An example of this is how the provinces in Canada influence decisions of the federal government on issues that are clearly within federal government jurisdiction. For an excellent example of this influence and how it actually operated, see Chapter IV in R. Simeon, Federal Provincial Diplomacy (Toronto: University of Toronto Press, 1972), pp. 66-87.

constitution that, at best, reflected the opinions of the authors as to what level of government should have certain legislative responsibilities and what revenue sources were required to fulfill these assigned responsibilities. For the period immediately following Confederation, this assignment was usually quite functional as there was a balance between revenue and responsibilities. Where problems do occur is when either level of government faces an increasing demand for its services without a corresponding increase in revenue or, conversely, where either level experiences a decrease in revenue without a corresponding decrease in expenditure responsibility. If this does occur, some method of transferring funds from one jurisdiction to the other must be found.¹ Of course, some federations have more flexibility built into their constitution than others; but, to a greater or lesser extent, this problem is characteristic of all federations.

¹The opposite could also occur. That is, the distribution of expenditure responsibilities could be altered between the two levels of government and result in a more balanced allocation of revenue sources and expenditure sources. But, while this is a possible solution to the problem, in most federations, and Canada is an example, a change in the constitutional division of powers is extremely difficult to bring about.

A. Canada's Situation

Canada is a classic case of imbalance of revenue sources and expenditure responsibilities. As Smiley has noted, the British North America Act of 1867¹ ". . . gave the federal authorities what were deemed to be the most important responsibilities of government."² Although there are specific examples in the B.N.A. Act of the kinds of responsibilities allocated to the central government, the grant was of a comprehensive nature to "make Laws for the Peace, Order and good Government of Canada, in relation to all Matters not coming within the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces" The responsibilities assigned to the provinces were of a much more limited nature. There was no general grant of legislative responsibilities to the provinces, and those responsibilities assigned were of a specific and local nature.³ Although the provinces were respon-

¹Hereinafter referred to as the B.N.A. Act.

²The major legislative responsibilities of the federal and provincial governments in Canada can be found in Appendix I, which is a reproduction of selected portions of the B.N.A. Act.

³D.V. Smiley, ed., The Rowell Sirois Report - Book 1 (Toronto: McClelland and Stewart, 1963), p. 50. There is a good description of the intended responsibilities in the new federation given in R.M. Dawson, The Government of Canada (Toronto: University of Toronto Press, 1970), pp. 57-75.

sible for local unit government, maintenance of public works, administration of local justice, a provincial prison system, education, and "The Establishment, Maintenance and Management of Hospitals, Asylums, Charities and Eleemosynary Institutions. . .", it was thought that the onerous burdens had been removed from their jurisdiction.

The allocation of financial power under the B.N.A. Act was in direct relation to the allocation of expenditure responsibilities and the perceived need for revenue to support these responsibilities in the future.¹ The Fathers of Confederation clearly saw the responsibilities assigned to the central government as being the most costly initially and the most likely to expand with time, and thus Section 91 (3) of the B.N.A. Act gave the central government the power for "The raising of Money by any Mode or System of Taxation". This was essentially a grant of general taxation power, which included indirect taxes as well as any direct tax

¹R.M. Dawson, The Government of Canada, p. 99. Chapter 6 of this work gives a good overview of federal-provincial relations in Canada.

the federal government wished to apply.¹ In the same manner, the responsibilities assigned to the provinces all involved modest expenditures, and it was thought that they would remain fairly static. Because of this, the major source of revenue for the provinces was not intended to be taxation. Provision was made for the payment of subsidies, by the central government to the provinces, and it was thought this would approximate 50 percent of the yearly provincial requirements.² It was only as a last resort that the provinces were expected to levy taxes; and, to curb any overly ambitious inclination

¹Although there is little consensus on the absolute distinction between a direct or an indirect tax, a simple criteria is where the final incidence is felt. If it falls directly on the person on whom it is levied, it is a direct tax. Examples of a direct tax are property tax, income tax, sales tax and licenses. If the tax can be passed on and not absorbed by the person on whom it is levied, it is an indirect tax. An example of an indirect tax is a custom duty. For a more elaborate description of direct and indirect taxes, see G.V. LaForest, The Allocation of Taxing Power Under the Canadian Constitution (Toronto: Canadian Tax Foundation, 1967), pp. 63-89.

²The actual fiscal transfer arrangements consisted of a payment to cover provincial indebtedness, annual grants to support provincial governments and legislatures, per-capita grants and special grants. For a description of these financial arrangements, see R.M. Dawson, The Government of Canada, pp. 99-104.

they were restricted to the rather unpopular direct tax.¹

B. Changing Circumstances

The original financial provisions for the provinces in Canada were based on a realistic balance between the revenue sources and expenditure responsibilities that existed in 1867. But, circumstances over which the provinces had virtually no control served to shatter this balance shortly thereafter, and the equilibrium has continued to erode to the present time. Specifically, certain functions that were allocated to the provinces, such as health, social welfare, and education, developed enormously and made demands on the provincial treasuries that were not anticipated. As an example of this increased provincial financial responsibility, in 1874 the expenditure of all the provinces for education and public welfare was only \$4 million; in 1937 it had increased to \$250 million; and in the late 1960's it had increased to \$2.5 billion.² While health expenditures per se

¹It is of note that direct taxes do have the ability to raise significant sums of money. This is perhaps shown by the revenue attributed to personal income tax. But, at the time of Confederation, direct taxation was seen to be particularly distasteful and, consequently, not conducive to raising large revenues.

²R.M. Dawson, The Government of Canada, p. 104.

were only one aspect of the increasing financial responsibilities that the provinces were incurring, it was a major and integral component of the problem. This is clearly represented by the fact that provincial expenditures on health at the provincial level were almost non-existent in 1867¹, while in 1973 the expenditures on just the services financed under the Medical Care Act and the Hospital Insurance and Diagnostic Services Act alone amounted to over \$3 billion.²

III - PROBLEM OF UNEQUAL TAX BASES AMONG REGIONAL GOVERNMENTS

"Within the boundaries of any unit of government -- a central government, a provincial or state government -- those living in certain areas will have higher real incomes than those living in adjacent areas because of differences in such factors as natural resources endowment, population concentration, and ability to attract entrepreneurial ability."³

The result of these differences is that some areas of a governmental unit will have a higher tax base

¹D.V. Smiley, ed., The Rowell-Sirois Report, p. 104.

²Canada. Annual Report Respecting Operations of the Medical Care Act (Ottawa: Department of National Health and Welfare, 1973), p. 20; and Annual Report Respecting Operations of the Hospital Insurance and Diagnostic Services Act (Ottawa: Department of National Health and Welfare, 1973), p. 32.

³J.H. Lynn, "Federal Provincial Relations," p. 197.

relative to other areas, and thus a higher per capita yield from a uniform tax structure. In a unitary state, the fact that certain areas contribute more revenue per capita is not a serious problem, as public services are usually provided to all residents regardless of their physical location or tax contribution.¹

In a federal state, the problem of providing similar government services is not as simple. This is especially so if the areas of regional jurisdiction are roughly co-terminous with high and low-income areas, as the provincial governments then have differing abilities to support services under their jurisdictions. Of course, in a federal state, some differences in service levels among regions are acceptable as a logical consequence of the autonomy enjoyed by the regional governments. But, if the differences are too marked, pressures may develop that could lead to individual states withdrawing from the federation. Therefore, in a federation, if there are significant differences in the regional

¹Conversely, the central government in a unitary state also has the option of making expenditures in a particular region, regardless of that region's ability to generate tax revenue. All that this necessitates on the part of the central government is determining the geographic area in which it will make the expenditures.

government's ability to provide an acceptable level of services, some mechanism must exist to transfer revenue to the low income area.

Canada is an excellent example of the regional disparity phenomena, and this has seriously affected the ability of certain provinces to support an equitable or nationally acceptable level of provincial services, including health care, without resorting to unduly high levels of taxation.¹

IV - PROBLEM OF DIFFERING PERSPECTIVES BETWEEN CENTRAL AND REGIONAL GOVERNMENTS

In determining the services or programs that should be government-sponsored, there is obviously a

¹P.E. Trudeau, Federal Provincial Grants and the Spending Power of Parliament (Ottawa: Government of Canada, 1969), p. 30. A working paper prepared for the Victoria Constitutional Conference, Ottawa, 1969. In this paper, Mr. Trudeau points out that:

"But in fact the tax-raising potential of Canada's provinces differs markedly across Canada, because of differing levels of income and economic activity in the country. One percentage point of personal income tax, for example, yields about \$3.14 per capita in Ontario, \$2.98 in British Columbia, \$2.21 in Quebec, \$1.89 in Saskatchewan, \$1.27 in New Brunswick, and 91 cents in Prince Edward Island (1968-69 figures). Similarly, one percentage point of corporation tax yields \$3.40 in Ontario, \$3.29 in British Columbia, \$2.39 in Quebec, \$1.82 in Saskatchewan, \$1.38 in New Brunswick, and \$1.00 in Prince Edward Island."

potential difference of opinion among those persons with a regional perspective as opposed to those persons who have a national perspective. In a unitary governmental structure, this difference in perspectives is accommodated by the central government in whatever manner it determines is most beneficial to the nation as a whole. In a federal system of government, for those functions that are under regional legislative jurisdiction, the resolution of the problem is compounded by the legislative superiority of the regional government. In commenting on why this difference in perspective exists between the two levels of government, P.E. Trudeau elaborated the following points.¹

Firstly, the terms of reference of the provincial government differ from those of the central government. One example of this difference in terms of reference is that the amount borrowed by a province is a function of what proportion of capital expenditures should be borne by present as opposed to future generations, their judgement as to the borrowing power of the province, and the general development of their respective economies. On the other hand, the central government makes its decisions on government debt policies based on the country's

¹Ibid., pp. 22-26.

total demand for capital and a desirable balance between fiscal and monetary policy.

Secondly, the priorities of the two levels of government are different. The regional governments are constrained by their constituents to primarily consider regional priorities, while the central government must consider the needs of a national constituency. An example in Canada of this difference in priorities is the development of transportation services. It seems only reasonable to assume that the regional governments would be primarily interested in intra-regional roads and streets and that this form of development would take precedence over inter-provincial highways that are located in the individual provinces.

Thirdly, the consequences of governmental policy and programs must be judged by the two levels of governments in terms of their overall responsibility. Trudeau rather succinctly described the rationale of this differing perspective when he wrote:

"This point is perhaps best illustrated by considering the national consequences of inaction on the part of some or all provinces. To take an extreme, if one of the provinces were to provide, for whatever reason, quite inadequate education, health and housing services, the rest of the country could be expected sooner or later to bear some of the "cost" of this inaction. A larger proportion of the labour force in those provinces would tend to be unemployed, the capacity of people to seek employment opportunities in areas where jobs were more readily available would be more

limited, and income would tend to be lower. In consequence the nation as a whole would be called upon to redistribute income to the people of those provinces, to provide equalization payments to their provincial governments, and to contribute to the economic development of the regions or areas involved.¹"

Canada has had a long history of federal involvement in financing and thus influencing programs under provincial legislative jurisdiction. In recent years, health care has been a major example of this involvement. Clearly, the federal government sees the provision of certain health care services that are under provincial jurisdiction as being in the national interest. This use of the spending power has created problems in federal-provincial financial relations, which will be discussed further in Chapter V.

¹Ibid., p. 26.

CHAPTER 3

FEDERAL INVOLVEMENT IN FINANCING

PROVINCIAL HEALTH PROGRAMS

I - INTRODUCTION

The purpose of this Chapter is to examine the federal government's role in financing health care programs that are under provincial jurisdiction. The first part of the Chapter will give a brief history of the overall federal involvement in financing health programs in Canada. The emphasis will then concentrate on the participation in financing provincial health programs. The remainder of the Chapter will examine the extent of the federal government's involvement at the present time. To facilitate this latter examination, the pertinent contents of the legislation that enables this involvement will be described. The specific legislation that will be described is the Hospital Insurance and Diagnostic Services Act, the Medical Care Act, the Health Resources Fund Act, the Canada Assistance Plan Act, and the Vocational Rehabilitation of Disabled Persons Act. The Chapter will conclude with some general observations that can be drawn on the basis of the description of the Acts.

II - FEDERAL GOVERNMENT'S HISTORICAL ROLE

A. Pre World War II

In Canada's early history, the federal govern-

ment's role in financing any health program was minimal.¹ Of course, the federal sphere has always been responsible for certain aspects of health that are enumerated in the B.N.A. Act. This original responsibility has subsequently been supplemented by certain conventions that have developed over time.² Before World War I, this essentially included expenditures on health care for sick mariners, prisoners, Indians, and Eskimos.³ Or, to describe the federal responsibility somewhat differently, Section 92 (7) of the Constitution assigned the responsibility of "The Establishment, Maintenance and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals" to the province, and it followed that only those areas of health care that fall outside this description were the responsibility of the federal government.

¹E.H. Hanson, Public Finance of Health Services (Ottawa: Queen's Printer, 1963), p. 31.

²The legality of the conventions that have developed over time is in question, but an example of what is referred to here is the federal government's role in providing and financing health care for Indians.

³E.J. Hanson, Public Finance of Health Services, p. 31.

The major support of any health care program by the federal government was initiated to support the after-care needs of veterans of World War I. It was approximately this same time that the first direct involvement of the federal government in financing a provincial health program came about. This was the venereal disease grant of 1919.¹

B. Post World War II

The federal expenditure on health care programs rose significantly after World War II. In the fiscal year 1947-48, the expenditure by the government of Canada on health totalled only an estimated \$57 million. In the fiscal year 1962-63, the expenditure had risen by approximately 750 percent to \$484 million, and in 1974 the total federal expenditure on health was over \$2 billion.²

The first major federal financing of health programs under provincial jurisdiction commenced in 1948 with the introduction of the general health grants program. The objectives of the general health grants were:

¹G.E. Carter, Conditional Grants Since World War II (Toronto: Canadian Tax Foundation, 1971), p. 21.

²E.J. Hanson, Public Finance of Health Services, p.31; and J.L. Fry, "Federal Involvement in Financing Health Services," (unpublished paper presented to the AUPHA Conference on the Canadian Health Care Delivery System, June 8, 1973), p. 6.

1. to help the provinces survey their health facilities and services;
2. to help the provinces expand and improve certain aspects of their health facilities; and
3. to assist the provinces in the construction of hospitals.¹

The general health grant consisted of nine (ten including the venereal disease grant of 1919) separate grants. Specific programs that the grants supported were: health surveys, hospital construction, crippled children, professional training, public health research cancer control, tuberculosis control, general public health, and mental health. Since 1948 the major additions to the original grants were: child and maternal health grant (1953); health resource fund (1966); hospital insurance and diagnostic services (1958); medical care (1968); and the national health grant (1969). In 1953 the crippled children program was expanded to include medical rehabilitation. Also, in 1971, all of the general health grants, with the exception of public health research and professional training, were phased out.² Two further acts that were passed by the federal government that have resulted in

¹Ibid., p. 7.

²Ibid., p. 8.

the federal government supporting health programs under provincial jurisdiction were the Canada Assistance Plan Act (1966) and the Vocational Rehabilitation of Disabled Persons Act (1961).¹ While support of health care programs under these two Acts is clear in some respects (i.e., the health care program under the Canada Assistance Plan), in other respects their role is not well understood and will be further elaborated on in this Chapter.

III - CURRENT FEDERAL INVOLVEMENT

A. Hospital Insurance and Diagnostic Services Act

The Hospital Insurance and Diagnostic Services Act was passed in 1957, but did not actually become operative until 1958.² Under the provisions of the Act, the federal government may enter into an agreement with any individual province to financially support a portion of the province's costs in operating specified hospital

¹One other federal program that was attempted was the Employment and Social Insurance Act of 1935. This Act was found ultra vires and thus the program was not implemented. For a further description of this point see the discussion on constitutional problems in Chapter V.

²Canada. Hospital Insurance and Diagnostic Services Act. Assented April 12, 1957 (Ottawa: Queen's Printer, 1957).

and diagnostic services for patients insured under provincial law. The actual operation of the program authorized by the Act will be described under (1) terms of agreement, (2) insured services (including exclusions), (3) tenure of the agreements, and (4) the federal contribution.

1. Terms of Agreement

The terms of agreement between the federal and provincial governments are enumerated in Section 5 of the Act.¹ Section 5(1) states that the agreement must specify the insured services to be provided, the amount of authorized charges, a schedule of provincial hospitals, and a scheme for the administration of the provincial law.² Section 5 (2) enumerates the provincial responsibilities under the agreement in that every province entering into such an agreement must ensure:

1. that services are available to all residents on uniform terms;
2. that adequate standards are maintained in hospitals;
3. that records acceptable to the Minister of National Health and Welfare are kept and

¹Ibid., Section 5 (1) (2) (3).

²Ibid., Section 5 (2), p. 6

and accessible to either the Minister
or his designate; and

4. that payments are not made to persons whose cost of services is the liability of another jurisdiction.¹

Section 5 (3) lists the responsibilities of the federal government under the agreement.² Specifically, the federal government must:

1. pay the provinces the authorized charges under the Act and its regulations; and
2. provide the provinces access to the reports and records pertinent to the calculation of costs.

2. Insured Services

Under the Act, both in-patient and out-patients services can be covered by the agreement. The in-patient services that are mandatory and thus provided for in all the agreements are listed in Section 2 (f).³ They are:

1. accommodation and meals in public wards;
2. necessary nursing services;
3. laboratory, radiological, and other diagnostic

¹Ibid., Section 5 (2), p. 6

²Ibid., Section 5 (3), p. 6

³Ibid., Section 2 (f), p. 4

procedures related to diagnosis, treatment and prevention;

4. drugs, biologicals, and related preparations when covered in the agreement and administered in hospital;
5. use of operating room, case room, and anaesthetic facilities along with the necessary equipment and supplies;
6. routine surgical supplies;
7. use of physiotherapy facilities;
8. use of radiotherapy facilities; and
9. other services that are specified in the agreement.

Section 2 (g) authorizes the federal government to make contributions toward the cost of any of the above services on an out-patient basis.¹ However, the law is not specific as to what out-patient services must be covered under the agreement and, thus, there is substantial variation in the individual agreements. The actual out-patient services that are insured in each province are described in Appendix II.

3. Exclusions from the Agreements

Section 2 (c) of the Act specifically excludes

¹Ibid., Section 2 (g), p. 4.

services provided in a tuberculosis hospital or sanatorium, hospital or institution for the mentally ill, nursing home, home for the aged, infirmary, or other custodial care institution.¹

The Act also excludes from shareable costs expenditures on capital costs of land, buildings or physical plant, payment of capital debt in force previous to the agreement, and any form of depreciation on land, buildings or physical plant. For purposes of interpretation of the Act, physical plant does not include furniture and movable equipment required for use in a hospital, and thus the original cost or depreciation on these items is shareable.²

4. Tenure of Agreement

Section 7 of the Act describes the tenure of any individual agreement. Basically, the agreement is of an unlimited nature, but it can be terminated in one of three ways. The first is, if the province fails to fulfill its responsibilities under the Act, the agreement

¹Ibid., Section 2 (e), pp. 3-4.

²The actual method of determining shareable costs is described as ". . . the operating costs of the hospital which have been determined in accordance with generally accepted accounting principles and procedures and approved by the provincial authority." Canada. Annual Report Respecting Operations of the Hospital Insurance and Diagnostic Services Act (Ottawa: Department of National Health and Welfare, 1972), p.32.

is inoperative. The second is, if the federal government gives notice of intention, the agreement expires in five years.¹ The third is that if both governments consent, the agreement can be terminated.

5. Federal Contribution

The federal contribution under the Act is described in Sections 7 and 8. While the actual calculations are quite complicated, basically the province receives 25 percent of the national per capita costs plus 25 percent of its own per capita costs multiplied by the number of residents in the province. The actual costs are calculated separately for both in-patient and out-patient programs, but the mechanism is the same. The total federal contribution under the Act is shown in Table 1.

Because the total federal contribution under the Act is calculated on an after-the-fact basis, there is a provision in Section 12 of the Regulations for the federal government to make advance payments to the provinces so that the provinces do not have to totally fund the program during the operating year. To ensure that the federal contributions are not resulting in overpayments, they are calculated on the basis of 22 percent of the national per capita costs, as opposed to the 25 percent in the final

¹The federal government gave the required notice in June of 1975. "Health Spending Limits Follow Ottawa Warnings," Edmonton Journal, June 24, 1975, p. 79.

TABLE 1
FEDERAL PAYMENTS MADE TO PROVINCES UNDER
THE HOSPITAL INSURANCE AND DIAGNOSTIC
ACT IN FISCAL 1972-1973

Province	Federal Contribution	% of Total Federal Contribution
Newfoundland	\$ 30,593,797	2.25
Prince Edward Island	6,238,364	.46
Nova Scotia	47,153,568	3.47
New Brunswick	39,292,800	2.89
Quebec	394,849,882	29.13
Ontario	485,045,969	35.78
Manitoba	64,445,410	4.76
Saskatchewan	55,194,049	4.07
Alberta	105,803,305	7.81
British Columbia	123,311,183	9.10
Yukon	932,004	.07
Northwest Territories	<u>2,509,915</u>	<u>.18</u>
Total	1,355,370,246	100.00

SOURCE: Annual Report, Hospital Insurance and Diagnostic Services Act, 1973, p. 31
(Adapted). The figure for the contribution to Quebec was obtained on p. 32.

calculation.

B. Medical Care Act

The Medical Care Act received Royal Assent on December 21, 1966.¹ The Act provides the legal mechanism for the federal government to financially participate in supporting medical services in an individual province. The actual features of the Act will be described under the same headings as those used for the previous section on Hospital Insurance and Diagnostic Services.

1. Terms of Agreement

The general terms of the agreement that apply to participating provinces are included in Section 4 of the Act.² Basically, these describe the criteria that the provinces must meet before they are eligible for signing an agreement under the Act with the federal government. They are as follows:

1. The plan must exist under an Act of the provincial legislature and be administered and operated on a non-profit basis by a public authority that has been appointed or designated

¹Canada. Medical Care Act. Assented December 21, 1966 (Ottawa: Queen's Printer, 1966).

²Ibid., Section 4 (1) (2) (3), pp. 3-5.

by the provincial government. This authority must be responsible to the provincial government for the administration and operation of the plan, and it must have its accounts and financial transactions audited by the official auditor. The designated authority may delegate any of its activities under the provincial law to other agencies as long as the activities that are delegated are subject to assessment and approval by the public authority.

2. The plan must provide for universal availability of all needed medical services to all eligible residents of the province under uniform terms and conditions.
3. The plan must not impose a waiting period of over three months before a new resident of the province is eligible for insured services. The plan must also provide for payment of services covered under the plan while a resident of a province is temporarily absent from the province. Also, if a resident moves to a province that participates under the plan but has a waiting period for coverage, the plan must provide insurance coverage for up to a three month period.
4. The plan must initially include 90 percent of

the insurable residents of a province, but after the province has participated for three years, the percentage of eligible population enrolled must be 95 percent.

The terms of agreement that apply to the federal government are only very briefly stated in the Act.

Section 3 merely states that a contribution is payable to the province by the federal government for costs incurred by the province in providing insured services.

2. Insured Services

Insured services under the Act are all services that are medically required and rendered by medical practitioners.¹ The only exception to this coverage is that, if a person is eligible for services under any other Act of Parliament or any provincial workman's compensation law, then the federal government is not responsible for supporting the cost of these services.²

3. Tenure of Agreement

There is no specific tenure of an agreement

¹Ibid., Section 3, p. 2.

²Specific exceptions are; prescribed drugs sold through retail outlets, services of private duty nurses, chiropractors, osteopaths, optometrists, dental services, prosthetic services, and naturopathy.

mentioned in the Act, other than the federal government must review the provisions of the Act by September 31, 1972.¹ Section 7 would seem to indicate that the federal government could discontinue the agreement if, in its opinion, the province is failing to live up to its obligations under Section 4 of the Act.²

4. Federal Contribution

Table 2 shows the federal contribution paid to the provinces under the Act in fiscal 1972-1973.³ It also shows, by province, the net population, the average number of insured persons, the total cost of insured services, the per capita cost of insured services, and the federal contribution.

The federal contribution under the Act is described under Section 5.⁴ The annual federal contribution to each province equals 50 percent of the national per capita costs of the insured services multiplied by the

¹Ibid., Section 8, p. 9.

²Ibid., Section 7, p. 8. Also the federal government gave notice that it was arbitrarily limited expenditures under the Act in June, 1975 "Health Spending Limits Follow Ottawa Warnings," Edmonton Journal, June 24, 1975, p. 79.

³Canada. Annual Report Respecting Operations of the Medical Care Act (Ottawa: Department of National Health and Welfare, 1973), p. 20.

⁴Canada. Medical Care Act, Section 6 (1) (2) (3) (4), pp. 5-6.

number of insured persons at each month end during the year.¹ The national per capita cost for a year is the aggregate of the cost of the insured services incurred by the participating provinces divided by the aggregate averages of the year of the number of insured persons in each of the participating provinces at the end of each month in the year.

As with the Hospital Insurance and Diagnostic Act, because the federal contributions are calculated on an annual basis, provision is made for advance payments to be made to the provinces. The advance payments are calculated by holding back up to 10 percent of the amount due to the province. The remainder of the contribution due to the provinces is submitted following the federal governments's receipt of the year-end cost reports from the provinces.²

¹Canada. Annual Report, Medical Care Act, 1973, pp. 17-18. There is difficulty in determining the average number of insured persons, as some provinces do not have premiums and there is also difficulty in obtaining reliable statistics from the premiums. As Table 2 indicates this could have a major effect on the lower population provinces.

²Ibid., p. 18

TABLE 2

FEDERAL PAYMENTS MADE TO PROVINCES UNDER THE MEDICAL CARE ACT IN FISCAL 1972-1973

Province	Net. Pop. Oct. 1/72	Average No. of Insured Persons	Cost of Insured Services	Per Capita Cost	% of Total Federal Contribution	Total Federal Contribution	Federal Contribution as % of Prov. Costs
Newfoundland	534,000	534,000	17,083,171	31.99	1.3	15,631,675	91.18
Prince Edward Island	113,000	113,000	4,595,645	40.67	.3	3,307,826	71.74
Nova Scotia	783,000	783,000	36,179,835	46.21	2.8	22,920,603	63.44
New Brunswick	640,000	640,000	24,060,926	37.60	1.8	18,734,592	77.92
Quebec	6,043,000	6,043,000	338,298,891	55.98	26.4	176,895,531	52.29
Ontario	7,835,000	7,827,165	531,455,985	67.90	41.5	229,123,037	43.11
Manitoba	986,000	1,014,846	47,166,614	46.48	3.7	29,707,384	62.98
Saskatchewan	909,000	917,500	43,418,094	47.32	3.3	26,857,794	61.86
Alberta	1,655,000	1,685,000	92,989,631	55.19	7.2	49,324,688	53.04
British Columbia	2,256,000	2,256,000	142,763,467	63.28	11.1	66,039,437	46.26
Yukon	19,000	19,000	732,435	38.55	.05	556,183	75.94
N.W.T.	37,000	37,000	1,618,955	43.76	.1	1,083,094	66.93
TOTAL	21,810,000	21,869,511	1,280,363,649	58.55	100.00	640,181,824	50.00

SOURCE: Annual Report, Medical Care Act, 1973, p. 20 (Adapted)

C. Health Resources Fund Act

The Health Resources Fund Act was passed on July 11, 1966.¹ Its overall purpose is to allow the federal government to financially contribute to the support of health training facilities in any of the provinces that wish to participate. This section will provide a general description of the program, and will specifically comment on: (1) the limitations on the total amount of cost sharing available to any one province, (2) exclusions from cost sharing, and (3) the federal contribution.

1. General Program

The Health Resources Fund Act legally formulates a Health Resources Fund (a special account of the Consolidated Revenue Fund) that can be used to financially support the planning, acquisition, construction, renovation, and equipping of health training facilities in any of the provinces.² Under the Act, a health training facility is defined as a school, hospital, or other institution that has a component of training or research related to the health field.³ The

¹Canada. Health Resources Fund Act. Assented July 11, 1966 (Ottawa: Queen's Printer, 1966).

²Canada. Annual Report Respecting Operations of the Health Resources Fund Act, 1973, p. 1.

³Canada. Annual Report, Health Resources Fund Act, Section 2, p. 1.

total amount of the fund is \$500 million, and it is to be allocated over the period from January 1, 1966 to December 31, 1980.¹ The fund is divided into three parts: \$300 million is allocated to the provinces on a per capita basis, \$25 million is designated for the Atlantic Provinces to support joint projects, and \$175 million could be allocated at the discretion of the government.² Contributions for any single project can cover up to 50 percent of the total provincial costs, but all contributions must be approved by the Minister of National Health and Welfare. Also, for any province to be eligible for cost sharing, it must submit a five-year development plan for health training facilities, and have it approved by the federal government.³

Under Section 4 (2) of the Act, the federal government allocated the \$175 million unallocated portion of the fund. This allocation gave \$100 million to the provinces on a 1966 census per capita basis, and \$75 million to support training and research projects of national significance.⁴

¹Ibid., Section 3 (2) (4), pp. 1-2.

²Ibid., Section 4, p. 2.

³Ibid., Section 7, p. 4.

⁴Canada. Annual Report, Health Resources Fund Act, 1973, p. 1.

2. Limitations on Cost Sharing

Section 4 (2a) stipulates the criteria for the allocation of the \$300 million portion of the fund.¹ It states that payments out of the fund to any one province cannot exceed the proportion of the \$300 million that the population of that province was to the population of Canada, according to the 1966 census. This limitation is not affected by the \$175 million portion of the fund allocated at the discretion of the federal government.

3. Exclusions from Cost Sharing

Section 6 of the Act describes the costs associated with acquiring, constructing or renovating a building for use as a health training facility that are not cost-shareable under the program. Specifically, these are:

1. cost of land;
2. interest payments associated with the project;
3. any amounts paid or payable out of the Consolidated Revenue Fund, under another Act, toward the cost of acquiring, constructing, or renovating a building for use as a health training facility; and

¹Canada. Health Resources Fund Act, Section 4 (2a), p. 2.

4. any amounts paid or payable by a province or municipality toward the cost of acquiring, constructing, or renovating a building for use as a health facility, where the funds were or are paid or payable out of the Consolidated Revenue Fund.¹

4. Federal Contribution

Table 3 shows the current status of the Health Resources Fund by allocations under the Act, approved projects, payments from 1966-1973, and unliquidated commitments.²

The method of reimbursement to the province by the federal government is described separately in the Act, according to whether the reimbursement is for planning, constructing, or renovating, or for acquiring a health facility.³ The reimbursement for planning and construction or renovation is basically the same, and is described in the Regulations under Section 4 and 6. Essentially, both of these are staged payments related to the portion of the project that is finished.

¹Ibid., Section 6, p. 6.

²Canada. Annual Report, Health Resources Fund Act, 1973, p. 16.

³Canada. Health Resources Fund Regulations, Sections 4 and 6, pp. 6-8.

TABLE 3
SUMMARY OF HEALTH RESOURCES FUND PAYMENTS 1966-1973
(000s)

Province	Allocations Under Act	Approvals	Payments 1966-1974	Unliquidated Commitments	% of Total Federal Allocations
Newfoundland	9,861	9,861	4,183	5,678	2.5
Prince Edward Island	2,169	626	624	1	.5
Nova Scotia	15,110	11,161	11,143	17	3.8
New Brunswick	12,327	4,085	3,850	235	3.1
Quebec	115,531	48,079	42,695	5,384	28.9
Ontario	139,114	109,322	95,073	14,248	34.8
Manitoba	19,247	10,110	7,125	2,985	4.8
Saskatchewan	19,093	13,617	10,141	3,476	4.8
Alberta	29,243	26,342	19,964	6,378	7.3
British Columbia	37,974	35,974	10,947	25,026	9.5
Yukon	287	-	-	-	-
N.W.T.	547	-	-	-	-
TOTAL	400,000	269,294	205,854	63,440	100.0
Allocation to Atlantic Provinces	25,000	19,169	10,855	8,313	
Other Allocations	75,000	10,000	447	9,307	
TOTAL	500,000	294,463	217,156	81,307	

SOURCE: Annual Report, Health Resources Fund Act, 1973, p. 15.

The only major difference is that the planning has four staged payments, while the constructing and renovating can have as few as two. The reimbursement when the province is acquiring a facility consists of one payment after the transaction has been completed. In all instances, the federal government requires that the province submit adequate information substantiating the transaction or progress on the project before any payment is made.

It is of note that under the Act most of the payments have been made to sixteen health sciences centres located in the various provinces.¹ While there is no breakdown for the last two years up to March 31, 1971, 95 percent of a total commitment of \$216,387,000 was as follows:

University of British Columbia	\$11,357,000
University of Alberta	10,187,000
University of Calgary	11,527,000
University of Saskatchewan	12,457,000
University of Manitoba	1,466,000
University of Western Ontario	23,414,000
University of Toronto	29,725,000
McMaster University	39,521,000

¹Canada. Annual Report, Health Resources Fund Act, 1971, p. 4.

Queen's University	3,040,000
University of Ottawa	107,000
University of Montreal	7,560,000
McGill University	10,091,000
University of Sherbrooke	14,315,000
University of Laval	8,810,000
Dalhousie University	21,839,000
Memorial University	641,000

D. Canada Assistance Plan

The Canada Assistance Plan was enacted on July 16, 1966.¹ The Plan is a mechanism for the federal government to aid in the integration, broadening, and improvement of provincial public assistance programs and to generally aid in the extension and development of welfare services to persons in need. The Plan has three sections: general assistance and welfare services, Indian welfare, and work activity. The general assistance and welfare services section covers what has traditionally been thought to be social welfare. The Indian welfare section provides for cost sharing provincial welfare programs that are extended to Indians. The work activity section refers to programs that assist a person to enter

¹Canada. Canada Assistance Plan Act. Assented July 15, 1966 (Ottawa: Queen's Printer, 1966).

or return to gainful employment. The part of the Plan that has relevance to financially supporting health programs under provincial jurisdiction is the general assistance section and thus the remainder of the discussion will refer to this section only.

1. Assistance on Basis of Need

One of the features of the Plan is that it provides for the open-ended granting of assistance on the basis of need as determined by the discrepancy between the person's budgetary requirements and his income and resources. Section 2 of the Act defines assistance and what types of assistance are included as cost-shareable under the Act.¹ Assistance means aid in any form given to a person in need for any or all of the following purposes:

1. food, shelter, clothing, fuel, utilities, household supplies, and personal requirements;
2. items required to carry out a trade or employment;
3. travel and transportation;
4. funeral and burials;
5. health care services;

¹Ibid., Section 2, pp. 1-2.

6. care in a home for special care;
7. comfort allowances;
8. welfare services purchased from an approved agency.

The definition of a person in need is also specified in Section 2. According to the Act, a person in need is anyone who, because of inability to obtain employment, loss of family provider, illness, disability, age, or other cause acceptable to the province, is unable to provide adequately for himself and his dependents.

2. Terms of Agreement

The general terms of any agreement under the Act are enumerated in Section 6,¹ and they must include:

1. a schedule listing the homes for special care and provincially approved agencies;
2. a schedule of the provincial Acts that apply under the agreement; and
3. a description of the information exchange that is required between the two governments.

The specific responsibilities of the province under the agreement are as follows:

1. it must provide assistance to any person in the province that is in need, in an amount that

¹Ibid., Section 6, pp. 3-10.

- takes into account his basic requirements;
2. it must not require a waiting period of residency to qualify for assistance;
 3. it must provide, within one year, a provision for appeal by assistance recipients; and
 4. it must ensure that its records are available for inspection by the federal government.

3. Method of Payment

The possible methods of payments under the Act are enumerated under Section 5.¹ While the possible methods of payment that the province may choose from are very complicated, essentially any of the methods chosen reimburse the province for 50 percent of their cost-shareable expenditures. In 1973 an amendment to the Act allowed for pre-payment before the end of the fiscal year.² Prior to this, the payment was on a year-end basis. The specific methods of payment relevant to this paper will be discussed under subsequent sections.

¹Ibid., Section 5, pp. 6-8.

²Canada. Annual Report Respecting Operations Under the Canada Assistance Plan Act (Ottawa: Department of National Health and Welfare, 1972), p. 3.

4. Tenure of Agreement

Section 8 of the Act describes the duration of any agreement under the Act.¹ In effect, any agreement under the Act remains in force as long as the provincial law authorizing payments for assistance meets the conditions required under the Act. The exceptions to this general principle are that:

1. an agreement can be terminated at any time by mutual consent;
2. an agreement can be amended at any time by mutual consent;
3. the province may give notice of intention to terminate any agreement at any time; and
4. the federal government may give notice to terminate an agreement any time after March 31, 1969.

5. Relationship to Health Care Financing

There are two aspects of the Act that specifically relate to financing health care programs that are under provincial jurisdiction. These are the health care services and the homes for special care programs.

Under the plan, the federal government can reimburse the province for 50 percent of its expenditures

¹Canada. Canada Assistance Plan Act, p. 10

on health care services provided for persons in need.¹ The actual services covered include medical, surgical, obstetrical, dental and nursing services, drugs, prosthetic appliances, and other items associated with the provision of health services. Section 5 (1) of the Act specifically excludes from cost-sharing services provided under any of the other federal-provincial cost-sharing programs. At the present time, this exclusion refers to services provided under the Hospital Insurance and Diagnostic Services Act and the Medical Care Act. Thus, the major areas of cost-sharing under the plan are on optical, dental and nursing services, drugs and medical supplies, and payment of medical insurance premiums for persons in need. The payments to the provinces under this part of the Act have steadily decreased since the institution of the Medical Care Act. As an example, in 1969-70 these were \$22 million, and in 1972-73 they had decreased to \$10.7 million.

While the relevance of the Canada Assistance Plan to health services as discussed in the foregoing paragraphs is relatively straight forward, the Act also

¹Ibid., Section 5, pp. 5-8.

²Canada. Annual Report Respecting Operations of the Canada Assistance Plan Act (Ottawa: Department of National Health and Welfare, 1973), p. 8.

provides for supporting persons in need that are resident in homes for special care. This latter point and its relationship to health care is anything but straight forward. To help clarify how this support takes place, a description of what constitutes a home for special care will be attempted. This will subsequently be followed by a description of how the Act applies to different types of health institutions that have been designed as homes for special care.

6. Description of Home for Special Care

The description of what constitutes a home for special care is included in a special document of the Department of National Health and Welfare, entitled Notes on Homes for Special Care.¹ In this document, a home for special care is described as a residential welfare institution, and includes homes for the aged, nursing homes, hostels for transients, child care institutions, homes for unwed mothers, and any welfare institution whose primary purpose is to provide residents with supervision, personal or nursing care, or social rehabilitation. Specifically excluded from qualifying

¹Canada. Notes on Homes for Special Care (Ottawa: Department of National Health and Welfare) Summer, 1967.

as a home for special care are hospitals, and this is interpreted to mean hospitals covered by the Hospital Insurance and Diagnostic Services Act, tuberculosis hospitals and sanatoria, institutions for the mentally ill and severely retarded, and institutions primarily administered for the purpose of providing medical care.

It was anticipated that problems would arise differentiating a home for special care from a health institution. If this occurred, the following factors would be considered:

1. the statutory authority under which the institution is operated;
2. the authority that is responsible for the administration of supervision of the institution (i.e., whether it is a medical or non-medical authority);
3. the relationship of the institution to other health and welfare facilities; and
4. the nature of the programs.

7. Application to the Nursing Home Field

If a province has entered into an agreement with the federal government under the Canadian Assistance Plan (C.A.P.), 50 percent of all assistance paid to residents in a nursing home is reimbursed to the province by the

in a nursing home is reimbursed to the province by the federal government.¹ This has been the case since the inception of the Act, and continues to be the case for provinces that do not have a universal nursing home plan.

When a province introduces a universal nursing home insurance scheme, the situation is somewhat different. Before February 1973, the federal government's interpretation of the Act was that only those charges directly attributable to the patient were eligible for cost-sharing. As an example, when the plan was of a co-insurance nature (like Alberta's) and the patient was required to pay only \$3 per day, if the resident qualified for assistance, only 50 percent of the \$3 qualified for cost-sharing. This situation led to a good deal of provincial dissatisfaction and, as a result, a new method of reimbursement was accepted by the federal government in February 1973.²

Although the new method of payment has not been ratified by Parliament, it is an attempt to ensure that provinces that have universal nursing home insurance plans are not financially penalized. For a province that

¹This information is based on an interview with Mr. D. Stolee, Deputy Minister of Social Services, Department of Health and Social Development, Alberta.

²This information was obtained from a memorandum distributed by the Department of National Health and Welfare, dated February 19, 1974.

introduces a nursing home plan in 1974, the formula for federal reimbursement would be:¹

$$\begin{aligned} \text{1974 Federal Payment} = & \\ \text{CAP Payment 1973} & \times \frac{\text{per diem cost 1974}}{\text{per diem cost 1973}} \times \\ & \frac{\text{population 65 + (1974)}}{\text{population 65 + (1973)}} \end{aligned}$$

8. Application to Mental Hospitals

In the past, at least one province had hospitals that were basically institutions for the care of psycho-geriatric patients, administered under their mental health services.² Under the Canada Assistance Plan, this province could not be reimbursed for costs it incurred for the support of any patients who qualified for assistance. Those hospitals were then removed from under mental health services and registered as homes for special care, and thus the expenditure by the province for the care of the residents who qualify for assistance is cost-shareable under the Act.

A situation that is very similar to the above is where a section of a mental hospital that housed

¹As is obvious from the formula, if any of the smaller provinces experienced a loss of population in the under 65 age group, the province could be faced with serious difficulties in financing its program.

²This was the situation that existed in Alberta, and examples would be the provincial government institutions at Camrose and Claresholm.

psycho-geriatric patients is administratively separated from the mental hospital and registered as a home for special care, and thus is eligible for cost-sharing. One province that successfully carried out this procedure was Saskatchewan, and it would seem that other provinces could probably use the same technique for cost-sharing some of the costs attributable to their psycho-geriatric patients.¹

9. Application to Hospitals for the Mentally Retarded

Historically, hospitals specifically for the care of the mentally retarded were operated by the division of government responsible for mental health services. These institutions were seen as hospitals, and thus the provincial cost of caring for residents that qualified for assistance was not cost-shareable. In much the same manner as with the hospitals for psycho-geriatric patients, it was found that if the province changed the authority under which the program operated and registered the institutions as homes for special care, they were eligible for cost sharing. As an example, in Alberta the two institutions for the mentally retarded at Red Deer are currently accepted

¹The hospital where this took place was in Saskatchewan Hospital, North Battleford.

for cost-sharing on this basis.¹

Although the actual expenditures by the federal government for this type of cost-sharing is not known (i.e., there is no financial breakdown of homes for special care dealing with the mentally retarded), the expenditure could be significant. As an example, if it is assumed that the cost per patient day is \$25., the proportion of the program cost-shareable is 80 percent,² and the total number of beds is 2,000, the total federal contribution would be \$5.84 million per year.³

10. Federal Payments

While it is impossible to specify the total federal expenditures on provincial health care programs under the Canada Assistance Plan, Table 4 shows the

¹Interview with Mr. M. Arcand, Director, Division of the Handicapped, Department of Health and Social Development, Alberta. Alberta Department of Health and Social Development, Homes and Institutions Branch. Internal memorandum describing the Homes for Special Care Operating in the Province of Alberta, July 1, 1974.

²The 80 percent is merely a hypothetical figure that assumes 80 percent of the residents would qualify on the basis of need.

³This does not seem to be an unreasonable figure for a province the size of Alberta. As an example, the licensed capacity of the two major important facilities for the retarded in Alberta is 2,100 patients.

TABLE 4
FEDERAL CANADA ASSISTANCE PLAN PAYMENTS FOR
MEDICAL SERVICES AND HOMES FOR SPECIAL
CARE 1972-73
(000s)

Province	Homes for Special Care	Health Care Services
Newfoundland	2,687	1,254
Prince Edward Island	1,916	50
Nova Scotia	4,925	304
New Brunswick	3,029	985
Quebec*	77,114	-
Ontario	34,091	1,289
Manitoba	6,008	1,565
Saskatchewan	3,597	1,668
Alberta	3,211	569
British Columbia	4,840	3,049
Total	141,428	11,869

SOURCE: Annual Report, Health Resources Fund Act, 1974 (Adapted).

*Payments made to Quebec for Health Care Services through the Established Programs (Interim Arrangements) Act were not reported. In fiscal 1971-72 they totalled \$1 million.

expenditures on health services and the overall expenditures on homes for special care in 1972-73. It must be emphasized, though, that the allocation for homes for special care is a global figure and does not really indicate the expenditure on health care programs.

E. Vocational Rehabilitation of Disabled Persons Act

The Vocational Rehabilitation of Disabled Persons Act was passed in 1961.¹ The Act allows the federal government to participate in the financing of a province's expenditures on a comprehensive program of rehabilitation for disabled persons. For the purpose of the Act, a disabled person refers to anyone who is incapable of regularly pursuing a substantially gainful occupation because of physical or mental impairment. Vocational rehabilitation is defined as any process of restoration, training, and employment placement that will allow a person to become capable of pursuing a substantially gainful occupation. A substantially gainful occupation means employment in the competitive labour market, in home-making, in sheltered employment, in home industries, or in other homebound work of a remunerative nature.

¹Canada. Vocational Rehabilitation of Disabled Persons Act. Assented January 26, 1961 (Ottawa: Queen's Printer, 1961).

Under the Act, a comprehensive rehabilitation program must include as a minimum the following components:¹

1. Assessment and counselling services.

This refers to all aspects of medical, social and vocational assessment that are required to determine whether the individual is capable of being rehabilitated to the extent that he can pursue a substantially gainful occupation. It also refers to the counselling that may be required to ensure that the individual can participate in a program of rehabilitation.

2. Restoration services.

Restoration services refer primarily to physical restoration services, and include prosthetic appliances, medical services, and paramedical services (i.e., physiotherapy). (It is of note that under this section of Albera's agreement it states: "It is not the intention of this agreement to supply complete health services to a segment of a population.")

The significance of this statement will become apparent under the relationship to financing health care.

¹The elaboration of these points is taken from the standard agreement under the Act that is signed between the federal and provincial governments.

3. Vocational training services.

Virtually all forms of training are potentially cost-shareable under the Act. It may be on either a full-time or part-time basis and can be given in vocational schools, private trade schools, special training centres, universities, and training on the job in business or industry. Also, where suitable training facilities are not available, and where the number of candidates justifies it, a special training program can be organized.

4. Employment placement services.

This merely refers to a service that attempts to place graduates of training programs into employment once they have completed their training program.

1. Shareable Costs.

The actual costs that are shareable are not enumerated in the Act. Basically, the costs that can be shared are described under the previous four points. The only exception to this is that any costs shareable under any other federal Act are not shareable under the Vocational Rehabilitation of Disabled Persons Act.

2. Tenure of Agreement.

Section 3 of the Act restricts the length of

any agreement under the Act to a maximum of six years. Any agreement under the Act can be terminated or amended during the life of the agreement with the consent of both the provincial and federal governments.

3. Relationship to Financing Health Care.

The Act quite clearly contributes to financing provincial health care costs under both assessment and counselling services and restorative services. The application to be described under this section is specifically in relation to programs associated with psychiatric hospitals.

All psychiatric hospitals have an element of vocational rehabilitation in their programs.¹ It may not be very well defined and be somewhat difficult to isolate, but it exists. In 1964 a psychiatric hospital in Saskatchewan decided to isolate from the rest of the hospital's programs those aspects of their program that had a relatively large vocational rehabilitation component. In the process they also attempted to upgrade the program in an attempt to ensure that when patients were discharged they would be capable of pursuing employment. Although this was a rather involved process, the changes were essentially as follows:

¹The information in this section is based on the author's own personal experience while employed at the Saskatchewan Hospital, Weyburn, and the Saskatchewan Hospital, North Battleford.

1. All patients that were "relatively" stabilized from a psychiatric point of view and who it was thought would have a greater chance of being successfully discharged if they could enter employment were placed in one area of the institution. (This does not mean that a large component of their program was not treatment-oriented, but merely that the predominant aspect of their program was vocational rehabilitation.)
2. The role of the nurses in these areas was changed from the traditional concept of nursing to more of a counselling emphasis.
3. A Department of Vocational Rehabilitation was set up with the responsibility of co-ordinating each patient's program and ensuring that a broad spectrum of vocationally-related activities were available for patients to be placed in for training. This department also had personnel attached to it who were responsible for counselling patients regarding their progress in the program and for finding job placements for patients once they were discharged.

After the program had been operating for some time, an application was made under the Vocational Rehabilitation of Disabled Persons Agreement to have the salaries of staff members working in the program cost-shared with

the federal government. Although not all of the personnel in the program were accepted for cost-sharing, a significant number were.

Subsequent to the successful cost-sharing of some of the hospital employees under the agreement, the same process was carried out at another psychiatric hospital and a hospital for the mentally retarded.¹

In the summer of 1962, the same process was initiated at the two large psychiatric hospitals in Alberta. This resulted in the cost-sharing of some personnel who had previously been turned down in Saskatchewan. While the extent of the cost-sharing under this agreement may not be large compared to some of the other federal-provincial agreements, in Alberta in 1972 the federal government contribution amounted to approximately \$500,000.²

IV - OBSERVATIONS

The foregoing Chapter has discussed in detail the federal involvement in financing provincial health

¹The psychiatric hospital was the Saskatchewan Hospital, North Battleford, and the hospital for the retarded was the Moose Jaw Training School.

²To the author's knowledge, no provinces in Canada, other than Alberta and Saskatchewan, have utilized the Vocational Rehabilitation of Disabled Persons Act to cost-share psychiatric hospital costs.

programs. It has shown that, following World War II, the federal participation was substantial and that participation was via cost-shared conditional grants. Specific observations that can be drawn on the basis of the information presented in the Chapter are:¹

1. The major federal expenditures are incurred under the Hospital Insurance and Diagnostic Services Act and the Medical Care Act. The expenditures under both of these Acts are open-ended with no restriction on the total federal contribution, other than that the expenditures must be authorized by the legislation and the individual agreements signed between the federal government and the provinces. Some of the expenditures under the Canada Assistance Plan are also open-ended but do not contribute significantly to overall provincial health expenditures. All of the expenditures under the Vocational Rehabilitation of Disabled Persons Act are of a closed-ended nature as are some of the expenditures under the Canada Assistance Plan Act.
2. The major expenditures under the Acts are for labour and supplies with only the Health Resources

¹Some of these observations will be elaborated on in Chapter V.

Fund Act supporting construction and the Hospital Insurance and Diagnostic Services Act providing support for some equipment.

3. The Canada Assistance Plan Act is being utilized to support provincial health care expenditures in a manner that is particularly difficult to deduce from the wording of the Act. One example of this is that the Act specifically states that a Home for Special Care is not to include institutions for the mentally ill and the mentally retarded.
4. The Vocational Rehabilitation of Disabled Persons Act is being used to support provincial expenditures on health care programs in a manner that does not appear to be equitable on an inter-provincial basis.
5. Some of the Acts are so generally or obscurely worded that it is virtually impossible to determine what can and cannot be cost-shared under them. While all of the Acts exhibit this to some extent, the Canada Assistance Plan Act is the best example. In fact, it would seem that, with careful perusal of the Act and its Regulations, it could cover virtually any form of government personal service expenditure.
6. Some of the Acts overlap in a manner that is not

particularly logical or functional. As an example, it would seem that, if the federal government wishes to support provincial expenditures related to institutions for the mentally retarded, one Act would be sufficient.

7. The funding under all of the Acts discussed is clearly related to health care, but the Acts themselves are relatively isolated. This contributes to undesirable fragmentation of finance and administration at both the federal and provincial levels with no single person having a total grasp of federal health funding possibilities and its relationship to provincial programs.
8. The long term commitment of the federal government to participate in the programs supported under the Acts varies. The Hospital Insurance and Diagnostic Act requires five years notice by the federal government. The Health Resources Fund Act commits the federal government until 1980. The Medical Care Act, Vocational Rehabilitation of Disabled Persons act and the Canada Assistance Plan can all be terminated or revised by the federal government with notice of one year or less.
9. The federal contribution under the Acts varies. The Medical Care Act reimburses the province on the

basis of 50 percent of the national per capita costs multiplied by the number of insured persons in that province. The Hospital Insurance and Diagnostic Services Act calculates the individual province's payments on the basis of 25 percent of the national per capita costs plus 25 percent of the provincial per capita costs. The Canada Assistance Plan Act reimburses the provinces for 50 percent of the provincial expenditure.

10. The major expenditures under the Acts are for acute treatment.
11. There is virtually no emphasis in the Acts on overall cost control.
12. There appears to be an attempt to roughly share costs on a 50-50 basis but there is not general consistency. It would appear that some of the Acts allow more freedom for the provinces to pursue their priorities while others give the advantage to the federal sphere.
13. The federal government is acting as a standard setter with its legislation but there are differing types of services provided in the provinces. An example of this is shown in Appendix 2 which describes the out-patient services provided under the Hospital Insurance and Diagnostic Services Act. It

would seem appropriate that these differences be investigated under all of the federal Acts discussed in this Chapter so that interprovincial inequity of services does not exist.

14. The total expenditures under the various Acts shows that a high percentage of the federally allocated funds go to Ontario and Quebec. Ontario has 35.7 percent of the insured persons under the Medical Care Act, but receives 41.5 percent of the federal allocation. In much the same manner Quebec only has 27.7 percent of the total population but 29.13 percent of the allocations under the Hospital Insurance and Diagnostic Services Act.

CHAPTER 4

RATIONALE OF FEDERAL INVOLVEMENT IN FINANCING PROVINCIAL HEALTH PROGRAMS

I - INTRODUCTION

The purpose of this Chapter is to examine in more detail, and from a broader perspective, the rationale of federal involvement. To accomplish this purpose, three particular subject areas will be discussed. First, the economic rationale will be examined. In this section, particular attention will be focused on a theoretical description of externalities and the possibility of their existence in provincial health expenditures. Second, the political rationale will be examined. In this section, the federal government's involvement in financing provincial health programs and its influence on the forces of federalism will be discussed. Third, an attempt will be made to present the social rationale related to federal involvement.

It is of note that, although the Chapter will discuss the economic, political and social rationale separately, this is an artificial fragmentation. In any policy decision on health funding in Canada, all three factors will be considered in concert. Therefore, to attempt to overcome this fragmentation, the final section of the Chapter will present a synthesis of the discussion.

II - ECONOMIC RATIONALE

The economic argument in support of federal involvement in financing provincial health programs is essentially based on the concept of external or spillover effects.¹ These concepts refer to the economic benefits and costs that accrue outside an individual province's jurisdiction as a result of expenditures within the province. Thus, if in the case of an individual province's expenditure, some of the benefits and costs related to that expenditure accrue outside the province's jurisdiction, the external accrual is described as an external economic effect. John Due, when writing about the case of externalities in education, rather clearly described the effect as follows:

"Many government services . . . result in spillover-external benefits to persons in other areas. Education is the classic example. Higher levels of education promote more stable and effective functioning of democracy, they bring more rapid technological change and economic growth, and higher levels of real per capita income. These benefits extend to the country as a whole, not merely to a particular school district or area. Secondly, persons are highly mobile . . . and migrate to other areas, which benefit from the education."²

¹The discussion in economic rationale relies heavily on the following two sources: J.F. Due, Government Finance: Economics of the Public Sector (Nobleton, Ontario: Richard D. Irwin, Incorporated, 1968), pp. 315-320; and G. E. Carter, Conditional Grants Since World War II (Toronto: Canadian Tax Foundation, 1971), pp. 5-20.

²J.F. Due, *ibid.*, p. 317.

The importance of external effects and its relation to financing provincial health programs is that, if the health expenditure has an external effect, it will not knowingly be supported by a province that is attempting to equate its marginal social costs and benefits and thus optimizing its expenditures. Or, to state the case somewhat differently, the optimizing province will equate its marginal social benefits and costs, but will not consider the benefits that accrue to the country as a whole.¹ Thus,

¹This discussion on marginal social benefits and costs implies more precision of measurement than actually exists. But the discussion is justified because, regardless of the precision of measurement, expenditure decisions include at the minimum a soft imputation of social costs and benefits.

The difference in desired expenditure patterns of the federal and provincial governments that are attempting to optimize their expenditures is indicated in the following equations:

Optimal Expenditure of Province:

$$\begin{array}{lcl} \text{Marginal Social Cost} & = & \text{Marginal Social Benefit} \\ \text{(Province)} & & \text{(Province)} \end{array}$$

Optimal Expenditure of Province from Federal Perspective:

$$\begin{array}{lcl} \text{Marginal Social Cost} & = & \text{Marginal Social Benefit} \\ & & \text{(Province) + Marginal Social} \\ & & \text{Benefit (Nation)} \end{array}$$

Difference in Optimal Expenditure Patterns:

$$\begin{array}{lcl} \text{Marginal Social Benefit} & - & \text{Marginal Social Benefit} \\ \text{(Nation)} & & \text{(Province)} \end{array}$$

It is important to note that the foregoing equations do not deal with optimal expenditure patterns between different goods and services; but, for the purpose of this discussion, they are related to health expenditures only.

from the national perspective, expenditures on provincial health programs will be sub-optimal. The degree of sub-optimality will be equal to the difference between the province's marginal social benefits and the national marginal social benefits.¹

Quite clearly, if there are external effects related to provincial health expenditures, this forms the basis of a rather persuasive argument in favour of the federal government participating in their funding. At least it would seem reasonable that, from a strictly economic point of view, a higher level of economic welfare would be desirable. But, while there may be a substantial theoretical argument supporting externalities related to at least some forms of provincial health expenditures, the

¹G.E. Carter, Conditional Grants Since World War II, p. 12. Although Carter uses somewhat different terminology, he describes the difference in perspectives and its effect as follows:

"According to the optimization rule . . . , a rational decision-making authority would strive to equate marginal costs and benefits of any program. But if the marginal social (i.e., national) benefits of a particular program exceed marginal community (i.e., provincial) benefits -- as they do when there are spillovers -- their expenditures on the activity would be sub-optimal. In other words, underspending on services will result if a community is aware that some benefits generated by it spending spill over to individuals outside The upshot is simply that some important public services will be undersupplied from the viewpoint of society as a whole."

existing evidence is not conclusive. This may be a function of the lack of interest shown by researchers in the area, or the general difficulty in objectively substantiating the external effect; but the fact remains that hard evidence in support of externalities of health expenditure is not readily available.¹

But, regardless of the evidence, it does seem at least intuitively reasonable that externalities do exist for at least some forms of provincial health expenditure.² Although the external effects could occur in a number of ways, the following points are at least an indication of their possible effect.³

1. If a health care expenditure resulted in increased productivity and its consequent higher income, external benefits could accrue because the persons who embody the human capital:

¹ Although most of the research into external effects has not been related to health expenditure, there has been some work in this area. As an example, G.F. Break found that significant externalities existed for expenditures on communicable disease control. G.F. Break, Inter-governmental Fiscal Relations (Washington: The Brookings Institute, 1967), p. 69.

² The areas where the greatest potential for external effects are those of public health, research and programs to change people's life style. But there is obviously considerable difficulty determining what health programs have external benefits.

³ It is realized that the elaborated points are only theoretically possible; but they are presented as an indication of possible external effects. Rigorous research would be required to substantiate any of them. Also the benefits in these cases would usually only be of significance in a federal state such as Canada.

- (a) would make higher federal and provincial tax contributions and thus a lower tax contribution would be required by others to maintain the same level of government services;
- (b) may migrate to another province and thus pay taxes to the new jurisdiction based on their increased income. This would in turn reduce the tax requirements on other residents of the new jurisdiction;
- (c) would reduce the need for transfer payments from the federal government to the province of migration and thus reduce the tax levied by the federal government.

Health programs in this category could include nutrition, repair of congenital defects, and some types of rehabilitation programs.

2. If a health care expenditure resulted in productivity being maintained, and thus income remaining higher than in the absence of the program, external benefits could accrue in virtually the same manner as under

point 1.¹

Programs in this category could include some forms of active treatment, prevention, and rehabilitation.

3. If a health care expenditure resulted in lower future maintenance costs for a particular disability, external benefits could accrue because of lowered transfer payments; or, if the person migrated, in lower maintenance costs for the host province.²

Some forms of rehabilitation and treatment maintenance programs would be in this category.

¹Weisbrod's study on polio, even though there are difficulties inherent in the design, indicates that one form of communicable disease program contributed to productivity levels being maintained, even though they were not improved. But in many respects, his study exhibits the potential external effect that treatment of a communicable disease in an individual province could have in Canada as a whole. Source: B.A. Weisbrod, "Costs and Benefits of Medical Research: A Case Study of Poliomyelitis," reproduced in H.S. Rucklin and D.C. Rogers, Economics and Health Care (Springfield, Illinois: Charles C. Thomas, 1973), pp. 178-196.

²Klarman's cost-effectiveness study on the best mix of institutional dialysis, home dialysis, or kidney transplant showed the possible lowered maintenance cost for renal disease. Source: H.E. Klarman, John O.S. Francis, and G.D. Rosenthal, "Cost-Effectiveness Analysis Applied to the Treatment of Chronic Renal Disease," reproduced in H.S. Rucklin and D.C. Rogers, pp. 196-206.

The economic argument against the federal government participating in the financing of health care is concerned with whether any form of artificial resource allocation to low income provinces is resource distorting or correcting.¹ Scott is the major proponent of the belief that all forms of artificial resource allocation are resource distorting and thus to the detriment of the country as a whole.² His argument is based on the classical economic theory that asserts that optimum resource allocation is attained by the uninhibited working of a perfectly competitive system and that only this system will result in maximum production, income and economic growth.

Buchanan, on the other hand, sees the situation

¹While the argument over artificial resource allocation is primarily concerned with equalization payments, it also applies to other federal funding. One example of this is conditional grant funding, where a province with a below-average income receives the same per capita grants as a high income province. Although it may not be called such, this in effect a form of equalization payment.

²H.D. Scott has written a number of articles outlining his position on any form of artificial resource allocation. See H.D. Scott "A Note on Federal Grants," Economics, XVII "Federal Grants and Resource Allocation," Journal of Political Economy, (December, 1952), pp. 534-538.

quite differently.¹ While he agrees that some forms of artificial resource allocation can be resource distorting, he emphasizes that the overall effect depends on what method is used to transfer the funds and what specific programs are supported. It is of note that Buchanan specifically makes the point that federal financial involvement in supporting some forms of provincial health programs would be resource correcting.²

III - POLITICAL RATIONALE

The political rationale in support of conditional health grant funding is based on the belief that when provincial health programs are supported and improved via federal government contributions, the forces of federalism are strengthened. This could obviously occur in many ways, two of which will be discussed.

First, the federal government's participation in financially assisting in the provision of provincial health programs could contribute to the citizens of Canada seeing the federal government in a legitimate and necessary role. This could, and probably did, occur in the case of medicare. Before the federal government became involved in the

¹J.M. Buchanan, "Federal Grants and Resource Allocation," Journal of Political Economy, LX (June, 1952), pp. 208-217.

²Ibid., pp. 212-213

program, only two provinces had comprehensive insurance for medical care.¹ While it is difficult to determine with any precision the support that the population at large had for the program, it is not unreasonable to assume that it was fairly strong.² Of course, there was some resistance to the program by certain provincial governments³ and organized groups;⁴ but there is no reason to suspect that the attitude of Canadians was anything but supportive.

¹British Columbia and Saskatchewan were the provinces that had programs somewhat similar to the program authorized under the Medical Care Act.

²While it is not possible to differentiate the influence of an individual election promise in an overall election, it is of note that a medical insurance program was an election promise of the liberals, and they were successful in the election. This could be interpreted as an indication of public support for the federal government to finance and thus influence a provincial health program. G.E. Carter, Conditional Grants Since World War II, p. 76. Also public support is indicated by the fact that the public does not seem anxious to remove Medicare.

³The Ontario Government's resistance to the Medical Care Act was extremely strong. For a further elaboration of the disagreement expressed by Ontario, see C.S. MacNaughton, "Ontario's View", in Canadian Federalism: Myth or Reality, edited by J.P. Meekison (2nd ed., Toronto: Methuen Publications, 1968), p. 297.

⁴The opposition of the Canadian Medical Association is documented in B.R. Blishen, Doctors and Doctrines (Toronto: University of Toronto Press, 1969), pp. 150-163.

Second, the Hospital Insurance and Diagnostic Services Act contributed to homogenizing hospital programs across the country. This could affect, even if in a subtle way, the attitude of the general population toward Canada in that it would highlight the unity of the country as opposed to a series of fragmented parts. While one must be careful not to overemphasize this point, the fact that one could travel or move to any part of the country and receive similar hospital care could not really have any other effect than to foster the unity of the nation in peoples' minds.

But, while the federal financial involvement could affect the attitudes of Canadians toward Canada in a positive manner, it also has the ability to fragment the country. The relationship between Ontario and the federal government is one example of the animosities that can develop between the two. This is clearly indicated in the following comments of an Ontario official that were delivered to the Federal-Provincial Conference of Ministers of Finance and Provincial Treasurers held in Ottawa in 1968:

"What assurance is there of any future consistency in federal financial policies? We find it ludicrous and incongruous that the Minister of Finance should, in the same budget speech, urge fiscal restraint, point the finger of blame at rising costs of provincial programs in which the federal government participates, and then insist on going ahead with medicare while saying that costs in the field are now under control. How does this reconcile with

the table prepared recently in the Department of Finance which projects rapidly increasing medicare costs over the first few years? What guarantee have we that, in a few years from now, the federal government will not dump the full responsibility for this program on the provinces and close off or limit its contributions after it has obliged the provinces to embark on this slippery slope?

It is obvious that the social development tax is a premium for medicare. In turn this coerces the Ontario taxpayer into a program, within the provincial jurisdiction, which the Ontario government does not believe to be required as a government scheme when nearly 95 percent of the people of the province already enjoy some form of medical care insurance. The fact that the federal tax increase is of an amount at least equivalent to the current federal estimate of its contributions to medicare in a full year is a clear indication of the federal intentions. We also regard it as nothing short of effrontery that this act should have been taken on the eve of a conference to discuss medicare . . ."¹

It is difficult to assess the significance of the foregoing comments and to separate the real strain that the program subjected federalism to, from the political maneuvering at such a conference. But, there does not seem to be much doubt that the overall effect was negative and thus a dysfunctional force on Canada's federal system.

Also, the problem of fragmentation has definitely been increased because of the recent escalation of health care costs which, at least in part, are related to the federal role in finance. At the present time, governments at both the federal and provincial levels are aware of the need

¹C.S. MacNaughton, "Ontario's View", p. 297.

to reduce costs, but the solution is not an easy one. The provinces are hesitant to change the current financial arrangements in case they "lose financial ground" in the process, and the discussions seem to have taken on overtones of blaming each other. But, which government to blame is not the issue; quite clearly, the issue is one of resolving the problem without an undue amount of strain on federal-provincial relations.

IV - SOCIAL RATIONALE

The social rationale in support of federal involvement in financing provincial health programs rests on the belief that the citizens of Canada feel a desire to ensure that the health needs of all Canadians are met in a relatively equal or similar manner. In turn, the only way in which the federal government can realistically ensure that adequate health services exist across Canada is through stimulation of provincial health programs by federal government financial participation. P.E. Trudeau stated the case for federal participation in financing provincial health programs as follows:

"Canadians everywhere now feel a sufficient sense of responsibility for their compatriots in other parts of the country that they are prepared to contribute to their well-being. They do so in a great many ways, the principle of which will always be income distribution payments directly to the people of other parts of Canada. But one of the most important ways of giving expression to their concern is by the provision to every citizen, wherever he lives, of adequate levels of public services -- in particular of health,

welfare and education services. Again some vehicle is required by which Canadians can achieve this goal -- by which the "national interest" in the level of general provincial public services or of a particular public service can be expressed."¹

Determining the validity of this "social concern" is problematic if for no other reason than the populations' preferences on the issue are not very objectively known. In fact, an argument could be made either in support or disagreement without the risk of anything but a personal value judgment reproach. This does not mean that the social rationale is necessarily lacking; in fact, under the circumstances, one (and perhaps the best) indicator supports it strongly. The federal government operates on a national mandate and has for some time supported federal involvement in financing health programs. While it could be argued that the federal government's preference is not a valid indicator of a general social concern, it could also be argued that it does represent the collective will of Canadians and is the best indicator we have at the present time.

V - OBSERVATIONS

This Chapter has examined the economic, political and social rationale of federal government participation in funding provincial health care programs. While it is

¹P.E. Trudeau, Federal Provincial Grants and the Spending Power of Parliament, pp. 28-30.

recognized that there are negative aspects associated with federal financial involvement, it seems reasonable to conclude that the argument in favour is superior for a number of reasons.

First, the economic spillover effect, although it is not well documented, is intuitively sound for at least some forms of health expenditures. In fact, it is so impressive that, for some health expenditures, it seems impossible for it not to exist. Of course, the benefits related to the economic spillover effect must be balanced against Scott's resource allocation argument, which in turn must be viewed in regard to Buchanan's viewpoint.¹

Second, on the basis of the positive and negative political effects presented in the Chapter, the balance would seem to be in favour of political unity as opposed to political fragmentation. Granted, some politicians make an issue of federal financial involvement in supporting provincial health programs; but it does not seem reasonable that this counteracts the national unity that this form of funding fosters. This does not mean that every effort should not be made to reduce the friction engendered by federal involvement, but merely that in

¹It would be tempting to infer that Buchanan's viewpoint is "more correct" than Scott's, but this type of assessment is beyond the competence of the author. Also, while the economic argument is valid, the level of spillover in most instances is probably not of a great magnitude.

determining the overall rationale of federal involvement, the national unity effect takes precedent.

Third, the social rationale in support of federal involvement really does not have an acceptable or adequate counter-argument. Individual Canadians' concern over fellow Canadians may, at times, not be very explicit; but it is very much an implicit aspect of our general social ethic and thus lends support to the federal government's involvement in financing provincial health programs.

There are two other observations that should be made at this point. The first observation is in relation to the type of mechanism that the federal government utilizes to support the provinces' health programs. In this regard, it seems obvious that the form of funding must be of a conditional type if the federal government is to achieve its objectives. Thus, whether the reason for federal support was clearly economic, political or social, or a combination of the three, the federal government's financial participation is a means to further its objectives. In order to meet these objectives it follows that, at least minimally, it must stipulate the particular programs it will support.¹

The second observation is in relation to the level of federal support. While it is difficult to determine the

¹Given the B.N.A. Act, the federal government really has no other alternatives.

level of federal financial support with any precision, the economic rationale at least indicates the theoretical level that can be economically justified. If one can accept that there are externalities related to some provincial health care expenditures and that the prime economic justification for federal support is the external effect of these expenditures, it then follows that federal support should be for those programs with external benefits. It also follows that the level of support should be equal to the external benefit. This, of course, implies that an identification of programs with spillover effects and the determination of the magnitude of the effect is possible. While this is a rather arduous task, it seems reasonable to assume that both programs and the magnitude of the external effect could be fairly objectively determined. After the specific programs and the magnitude of the external effect have been determined, if the federal government wants to economically optimize its expenditure on any provincial health program, it should reimburse the province in a conditional manner in an amount equal to the external effect. That is, if the marginal social benefits of a program from the national point of view on any provincial health expenditure exceed the marginal social benefits from the provincial point of view by a certain factor, the optimizing federal contribution would be equal to that factor.

CHAPTER 5

PROBLEMS ASSOCIATED WITH FEDERAL INVOLVEMENT IN FINANCING PROVINCIAL HEALTH PROGRAMS

I - INTRODUCTION

The purpose of this Chapter is to examine the major problems associated with conditional health grant funding. It will further attempt to determine the legitimacy of these problems as a criticism of conditional health grant funding. The specific problems discussed will be those associated with constitutional issues, cost escalation, provincial priority distortion, negative incentives, lack of co-ordination, and provincial manipulation.

II - CONSTITUTIONAL PROBLEM

The constitutional issue over conditional funding of provincial health programs is basically a disagreement over the interpretation of the B.N.A. Act.¹ The provinces

¹It is realized that the constitutional problem of conditional finance of provincial programs is much broader than just in relation to health financing, but it is also very much an aspect of the health finance situation. This is especially so when it is realized that federal expenditures under the Hospital Insurance and Diagnostic Services Act and the Medical Care Act are two of the most expensive conditional grant programs in operation. See Table 1 and 2.

feel that, because Section 92 (7) allocates the responsibility for health care to the provinces, any use of conditional health funding constitutes an invasion of provincial jurisdiction and is, therefore, unconstitutional. On the other hand, the federal government believes that Section 91 (3), which gives Parliament access to any form of taxation, and Section 91 (1a), which confers on Parliament the right to pass legislation respecting debt and property, justify this form of expenditure. Also, the federal government has justified conditional grant funding on the basis of the prerogative of the Crown and common law.¹

The only conditional grant that has been tested in the courts was the Employment and Social Insurance Act of 1935. On appeal, the Judicial Committee of the Privy Council concurred with the belief that the federal government could tax by any mode, but qualified its power to spend as follows:

"That the Dominion may impose taxation for the purpose of creating a fund for special purposes and may apply that fund for making contributions in the public interest to individuals, corporations, or public authorities, could not as a general proposition be denied But assuming that the dominion has collected by means of taxation a fund, it by no means follows that any

¹The constitutional issue related to conditional grant funding is thoroughly discussed in D.V. Smiley, Conditional Grants and Canadian Federalism (Toronto: Canadian Tax Foundation, 1963), pp. 17-27. The first section of this Chapter relies heavily on Smiley's discussion.

legislation that disposes of it is necessarily within Dominion competence.

It may still be legislation affecting the classes of subjects enumerated in Section 92, and, if so, would be ultra vires. In other words, Dominion legislation, even though it deals with Dominion property, may yet be so framed as to . . . encroach upon the classes of subjects that are reserved to provincial competence. . . . If on the true view of the legislation it is found that in reality in pith and substance the legislation . . . encroaches upon the provincial field, the legislation would be invalid. To hold otherwise would afford the Dominion an easy passage into the provincial domain."¹

Attempting to determine the current legal status of federal conditional health grant funding is extremely difficult, as the more recent references to its constitutionality are, at best, conjectural. With this qualification, some opinions as to their status will be presented; but it must be noted that they are only opinions and do not have any basis in law.

A. Opinions Regarding Constitutionality

In 1939 L.M. Gouin and B. Claxton published a report on the constitutionality of federal conditional grants. The major finding of this study was that conditional health grants were constitutional as long as the Dominion statute only authorized the federal government to make the funds available for provincial purposes but did not specify restrictions on how the funds were

¹Quoted in D.V. Smiley, *ibid.*, p. 19.

to be spent.¹

"Since there can be little doubt that the Dominion, under its general power to deal with the public debt conferred by 5.91 (1), can expend its own money as it wills, even under provincial objects, it is submitted that all such grants made without special statutory authority are intra vires the Dominion."²

The Quebec Royal Commission on Constitutional Problems in 1954 denied the constitutionality of conditional grant funding for any program under provincial jurisdiction.³ In essence, the Commission refuted the doctrine that the federal government had an unrestricted taxing and spending authority. Some of the reasons it presented in support of its findings were:

1. If the B.N.A. Act was intended to allow the federal government to tax for provincial purposes, it would specifically state this;
2. The idea of federation does not include one

¹It appears that the specification of restrictions that Gouin and Claxton are referring to is to be interpreted as legislative restrictions, but this is not at all clear. This becomes particularly problematic when one considers that all federal expenditures require at least subordinate legislation designating what the purpose of the expenditure is for. Thus, although they are saying that some forms of federal expenditure on provincial programs are constitutional, they are in fact contradicting this assertion by stating that, if it is legislatively stipulated how the funds are spent, the expenditures would be unconstitutional.

²D.V. Smiley, Conditional Grants and Canadian Federalism, p. 20.

³Ibid., pp. 21-22.

government assessing taxes for other than its own purposes; and

3. The decision of the Privy Council on the Employment and Social Insurance Act.

Taking a different stance than the two reports cited, F. Scott does not support any limitations on this form of federal spending power.¹ He bases his argument on the prerogative of the Crown and common law, and not the issue of Parliament's jurisdiction over public debt and property.

"The Crown is a person capable of making gifts or contracts like any other person to whomsoever it chooses to benefit. The recipient may be another government or private individuals Moreover, the Crown may attach conditions to the gift, failure to observe which will cause its discontinuance. These simple but significant powers exist in our constitutional law though no mention of them is made in the British North America Acts. They derive from the Royal Prerogative and the common law."²

In 1957 Prime Minister St. Laurent justified conditional grant expenditures in a similar manner as Scott by describing them as an exercise of "the royal prerogative to apply public funds to matters that would be of value to the national development or to the welfare of the nation as a whole".³ He also noted that many precedents had been

¹Ibid., p. 22.

²Quoted in D.V. Smiley, *ibid.*, p. 22.

³Quoted in D.V. Smiley, *ibid.*, p. 23.

set for this use of the spending power as long as:

1. the funds came from the consolidated revenue fund;
2. the expenditure did not involve an element of compulsion; and
3. the federal legislation did not amount to control of the administration or operation of the provincial functions.

The contemporary case in support of conditional grant funding is probably best summed up in a document by P.E. Trudeau, entitled Federal Provincial Grants and the Spending Power of Parliament.¹ While Trudeau recognizes and comments on the constitutional problems related to this use of the spending power, he clearly sees it as within the jurisdiction of the Parliament.

"In addition to the powers of the Parliament of Canada to legislate, the Constitution as it has been interpreted by the courts gives to it the power to spend from the Consolidated Revenue Fund on any object, providing the legislation authorizing the expenditures does not amount to a regulatory scheme falling within the provincial powers."²

Assessing how important the constitutional problem related to conditional grant funding is, is essentially a matter of determining:

¹P.E. Trudeau, Federal Provincial Grants and the Spending Power of Parliament.

²Ibid., p. 12.

1. the probability of having the issue submitted to the courts; and
2. what the outcome of the court's decision will be.

As would seem fairly obvious, the outcome of the court's decision is indeterminate, and little can be said other than to make the point that any decision ruling against this form of funding would seriously disrupt the financing of provincial health programs. But, while the potential of an adverse ruling is of some concern, what is of real importance is the probability of having the issue submitted to the courts. While it is impossible to state with any certainty whether this will occur, a statement by J.A. Corry could help put the issue in perspective.

"At first glance, it seems extraordinary that no one has challenged the constitutionality of the assumed spending power before the Supreme Court Yet, a little reflection will show that the proof of the unconstitutionality of federal spending for objects outside federal legislative power would be too much for almost anybody's comfort. A great many of the substantial interests of the country now derive advantages from it, and the rest have not given up hope of doing so. The provincial governments . . . do not want to challenge it. Federal spending now supports so much of the established political, social and economic structure that prudent men hesitate to take steps that might wipe it out."¹

¹Quoted in D.V. Smiley, Conditional Grants and Canadian Federalism, p. 24.

Granted, Corry is talking about a broader field than just health financing; but if he is correct, then the constitutional problem over conditional health funding is not a major issue. It may continue to be internally disruptive; but, in a legal or constitutional sense, it may never come to the fore.

III - COST ESCALATION

The increase in expenditures on health care programs in Canada has been substantial. In 1960 Canada's total expenditure on health care was \$2.1 billion, and this represented 5.5 percent of the GNP.¹ In 1971 this expenditure had risen to \$6.5 billion and exceeded 7 percent of the GNP.² In view of the fact that expenditures under the Hospital Insurance and Diagnostic Services and the Medical Care Acts make up 68 percent of the total health spending, it seems reasonable to conclude that they played a role in this increase.³

As an example, Table 5 shows that expenditures on general and allied hospitals -- which primarily consist of hospitals funded under the Hospital Insurance and

¹Canada's Hospitals and Health Services Systems (a special report prepared by Hospital Administration in Canada, Toronto, May, 1973), p. 55.

²Ibid., p. 55.

³Canada. Expenditures on Personal Health Care in Canada (Ottawa: Department of National Health and Welfare, 1973), p. 9.

TABLE 5

SELECTED STATISTICS DESCRIBING GENERAL AND ALLIED
HOSPITAL EXPENDITURES IN CANADA, 1960-71
(000s)

Year	Total Expenditure	Percentage Increase ¹	Expenditure Per Person	Percentage of GNP ^{2,3}	Percentage of Total Personal Health Expenditures ^{3,4}
1960	640,587	--	\$ 35.77	1.67	44.4
1961	727,057	12.7	39.52	1.82	45.4
1962	811,848	12.4	43.61	1.89	47.0
1963	909,762	12.1	47.97	1.98	47.2
1964	1,015,148	11.6	52.53	2.02	47.8
1965	1,144,479	12.7	58.16	2.07	48.1
1966	1,319,048	15.3	65.79	2.13	49.2
1967	1,523,035	15.5	74.61	2.29	49.9
1968	1,789,968	17.5	86.35	2.47	50.9
1969	2,024,735	13.1	96.29	2.54	51.1
1970	2,302,580	13.7	107.96	2.69	51.4
1971	2,594,564	12.7	120.15	2.79	50.8

¹Percentage increase over previous year's expenditures.

²Percentage of GNP at market prices.

³Percentage increase of GNP from 1960-1971 is 67%.

⁴Total Personal Health Expenditures do not include community public health, professional training and research, and outlays for construction of facilities.

SOURCE: Canada. Expenditures on Personal Health Care in Canada, pp. 5-9.

Diagnostic Services Act -- were \$640 million in 1960. By 1965 they had risen to \$1.1 billion, and in 1971 were \$2.6 billion. Throughout this period, the percentage increase from year to year was approximately 13, with a low of 11.5 registered in 1964 and a high of 17.5 in 1968. The percentage of the GNP accounted for by these expenditures also rose dramatically over the years. In 1960 it was 1.67; in 1965 it had increased to 2.07; and in 1971 it was 2.79 percent. It is also of note that, as a consequence of all expenditures on personal health services, this category rose from 44.4 percent in 1960 to 50.8 percent in 1971.

Expenditures on physician's services is very similar to hospital expenditures. Table 6 shows that in 1960 the total cost for physicians' services was \$355 million. In 1966 this expenditure had risen to \$686 million, and in 1971 to \$1.2 billion. It is of note that the lowest increase over this period was 13.4 percent in 1967, and it was highest in 1971, with an increase of 20.1 percent.

While the foregoing figures have been used to implicate conditional health grant funding as a factor in the escalating cost of health care in Canada,¹ there is

¹L.F. Detwiller, The Consequences of Health Care Through Government (Sydney, Australia: Office of Health Care Finance, 1972), pp. 11-13.

TABLE 6

SELECTED STATISTICS DESCRIBING EXPENDITURES ON
PHYSICIANS' SERVICES IN CANADA, 1960-71
(000s)

Year	Total Expenditure	Percentage Increase ¹	Expenditure Per Person	Percentage of GNP ²	Percentage of Personal Health Expenditure ³
1960	355,014	--	19.82	0.93	24.6
1961	388,304	9.4	21.25	0.98	24.4
1962	406,075	4.6	21.82	0.95	23.5
1963	453,395	11.7	23.91	0.99	23.5
1964	495,657	9.3	25.65	0.99	23.4
1965	545,056	10.0	27.70	0.98	22.9
1966	605,200	11.0	30.19	0.98	22.5
1967	686,187	13.4	33.62	1.03	22.5
1968	788,088	14.9	38.02	1.09	22.4
1969	901,435	14.4	42.87	1.13	22.8
1970	1,208,900	14.1	48.24	1.20	23.0
1971	1,236,182	20.1	57.24	1.33	24.2

¹ Percentage of increase over previous year's expenditures.

² Percentage of GNP at market prices.

³ Total Personal Health Expenditures do not include community public health, professional training and research, and outlays for construction of facilities.

SOURCE: Canada. Expenditures on Personal Health Care in Canada, pp. 5-9.

a problem in determining to what extent conditional funding, per se, is responsible. In fact, an argument could be made that the provinces themselves precipitated the expenditure increases. The provinces could effectively reduce the cost of health care by the simple process of introducing some economic constraints to the consumption of service. An example would be introduction of deterrent fees which is not a widely used practise at the present time.¹ Also, control of the medical profession (which is the basic generator of health care costs) is a provincial responsibility; but few, if any, provinces have taken any meaningful steps to control this cost-inducing group. Relating cost escalation to the existing conditional grants is difficult because of the lack of comparable figures to indicate the costs over the same period had the grants not existed. While this may, on the surface, seem to be stretching a point, the United States' experience, which has not been affected by major conditional grant programs for medical or hospital care, has shown approximately the same relative increase in expenditures as has Canada.² In fact, the percentage of GNP expended on all health care in the United States in 1971 was 7.6, while in

¹Canada. Annual Report, Medical Care Act, 1973, pp. 5-15; and Annual Report, Hospital Insurance and Diagnostic Services Act, 1973, pp. 4-5.

²Canada. National Health Expenditures in Canada, Table 2.

Canada it was 7.1.¹

IV - PRIORITY DISTORTION

Perhaps the major provincial criticism of conditional grant funding is that the grants interfere with provincial expenditure priorities.² This view was quite forcefully expressed by J. Robarts, a former premier of Ontario, when he said:

"Massive spending initiatives by the federal government, such as medicare, not only rob provincial budgets of any flexibility, but also undermine any real progress toward over-all control of expenditures by all governments and fail utterly to recognize provincial priorities We are being pushed into medicare which, from the point of view of this government, is not necessary in the province at this time and is not one of our top priorities."³

If Mr. Robarts is correct in his assertion that conditional grant funding does severely distort provincial priorities, at least from the provincial point of view, this would constitute a major problem. But, on the other hand, this must be balanced against the federal argument that the basic purpose of the funding is to stimulate provincial expenditure. Thus, the problem is not so much a matter of whether provincial priorities are dis-

¹Ibid., Table 4.

²This is true only when the grants are of a shared-cost nature.

³J.C. Strick, "Conditional Grants and Provincial Government Budgeting," Canadian Public Administration, Vol. 14, No. 2 (Summer, 1971), pp. 225.

torted, but is more an issue of degree. Obviously, if the funding severely inhibits a province's ability to pursue other long-run policies such as industrialization, the overall effect could be to the detriment of all Canadians.

In 1972 J.C. Strick carried out a study that concluded that, on an aggregate basis (all provinces combined), significant priority distortion did not occur.¹ His figures show that in 1954, before the introduction of either of the major conditional health grants, 17.3 percent of the net provincial expenditure was on health care.² In 1958 it had decreased to 15.2 percent; in 1967 it was 18.3 percent; and in 1970 it was 18.5 percent. While Strick's study disagreed with the priority distortion assertion, there are a number of problems in accepting his conclusions at face value. First, his study was on an aggregate basis and does not indicate the effect on the lower income provinces. Second, from 1954 to 1970 there was an increase in the overall spending of the provinces, and even though the percentage of net provincial expenditures remained relatively constant, the provinces may not have wanted to increase their expenditures on health at the same rate as other areas. If

¹Ibid., pp. 217-235.

²Ibid., pp. 230-232.

this was the case, a major priority distortion could have occurred without being indicated in the percentage of actual expenditures.

In attempting to determine the overall affect that conditional health grant funding has had on provincial expenditure priorities, it seems reasonable to conclude that it has had some effect, while the magnitude of the effect at the present time is unknown. But, in much the same way that the cost escalation problem is not necessarily related to the actual conditional grant mechanism, the same holds true in relation to priority distortion. The existing grants may distort provincial expenditure priorities, and the distortion may be significant, but this is more of an indictment of the design than of the method.¹

¹This does not mean that, when the grant is of a cost-share type, provincial expenditures priorities are not affected. If the province has the freedom to spend fifty cent dollars, they will probably allocate more resources from a total point of view to the program. But before this allocation actually affects the overall priorities, at the provincial level, the allocation would have to double the expenditure, had the shared-cost program not existed. This point is discussed in Spyros Andreopolis, ed., "National Health Insurance", (Toronto: John Wiley and Sons, 1975) p. 81.

V - NEGATIVE INCENTIVES

One of the purposes behind the federal government's involvement in financing provincial health programs is to stimulate provincial expenditures on certain programs. One instance where the mechanism for calculating provincial payments could work in opposition to this objective is the Medical Care Act. As was described in Chapter III, the federal payment under the Medical Care Act is determined by multiplying the national per capita expenditure by the number of insured persons in the province. This could result in a province, and especially a small province, minimizing its expenditures on the program and yet receiving a national average per capita payment.

As an example, Table 7 shows that in 1973 Newfoundland and New Brunswick had per capita costs of approximately \$32 and \$37 respectively, while the national per capita cost was \$58.55. This resulted in the federal contribution to Newfoundland being \$15,631,675, while its actual cost of ensured services was only \$17,083,171.¹ In the same year, the federal contribution to New Brunswick was \$18,734,592, while its actual cost was \$24,060,926. The result of this form of cost reimbursement

¹Fifty percent of Newfoundland's actual per capita cost would only have resulted in a federal payment of approximately \$8.5 million. The figure for New Brunswick would have been approximately \$12 million.

TABLE 7

MEDICAL CARE FEDERAL CONTRIBUTION
1972-73

Province	Average No. of Insured Persons	Cost of Insured Services	Per Capita Cost	Total Federal Contribution	Percent* Federal Contribution
Newfoundland	534,000	17,083,171	31.99	15,631,675	91.5
Prince Edward Island	113,000	4,595,645	40.67	3,307,826	71.9
Nova Scotia	783,000	36,179,835	46.21	22,920,603	63.4
New Brunswick	640,000	24,060,926	37.60	18,734,592	77.9
Quebec	6,043,000	338,298,891	55.98	176,895,531	52.3
Ontario	7,827,165	531,455,985	67.90	229,123,037	43.1
Manitoba	1,014,846	47,166,614	46.48	29,707,384	63.0
Saskatchewan	917,500	43,418,094	47.32	26,857,794	61.8
Alberta	1,685,000	92,989,631	55.19	49,324,688	53.0
British Columbia	2,256,000	142,763,467	63.28	66,039,437	46.3
Yukon	19,000	732,435	38.55	556,183	75.9
N.W.T.	37,000	1,618,955	43.76	1,083,094	66.9
TOTAL	21,869,511	1,280,363,649	58.55	640,181,824	50.0

* Calculated by Author

SOURCE: Annual Report, Medical Care Act, 1972-73, p. 20 (Adapted).

is that over 90 percent of the cost of medical care in Newfoundland was paid by the federal government, while in New Brunswick the federal contribution was over 70 percent.

Although it would be difficult to verify, and it is not implied that either Newfoundland or New Brunswick restrict their expenditures on physicians' services, it does seem possible that, given the reimbursement method under the Act, some provinces could find it advantageous to restrict expenditures under the program. As an example, the Hospital Insurance and Diagnostic Services Act authorizes the federal government to contribute 25 percent of the national per capita cost, and 25 percent of the individual provinces actual costs.¹ This technique could encourage costs incurred to tend toward the national average and, presumably this method could be instituted for payments under the Medical Care Act.

VI - LACK OF CO-ORDINATION

The federal financing under the Medical Care Act and the Hospital Insurance and Diagnostic Services Act is currently organized under one administration.² One area that is closely related to this form of financing and

¹See Chapter III and the description of the authorized program under the Hospital Insurance and Diagnostic Services Act (p. 26).

²Canada. Annual Report, Medical Care Act, 1973, p. 2
As noted previously most of the provinces administer the programs under these two Acts separately.

which is seen, at least at the provincial level, as being related to the same overall program is the care provided in nursing homes. At the present time, the federal role in supporting nursing home care is administered separately as a part of the Canada Assistance Plan. While the extent of the problem that stems from this separation has not been specifically defined, it is obvious that, if the programs were administered together, there would be more of an opportunity for the federal view to reflect the continuum of care between nursing homes, auxiliary and acute treatment hospitals, and the medical practitioner's relationship to all three. At the present time the mandate of the Hospital Insurance and Diagnostic Services program is clearly related to financing acute treatment and auxiliary care, but these are the most expensive components of the health care system. The result could be, and probably has been, for the federal Act to perpetuate an orientation to the most expensive form of hospitalization.¹

In much the same manner, the Canada Assistance Plan support of residents in hospitals for the mentally retarded, and the Vocational Rehabilitation of Disabled Persons support of mental hospitals is in many respects

¹This problem is increased when one considers that the only federal support available for nursing homes is related to those residents that are defined as "in need" and thus does not affect all nursing home residents.

an artificial separation. At the provincial level, it is recognized that care in any type of hospital is contingent on its relationship to other hospitals, and that patients move among all types of hospitals depending on their needs. Therefore, it would seem reasonable that any form of federal financial support for hospitalization of any type should ensure that the provincial system is not being fragmented into artificial components. Or, to state it somewhat differently, if the hospitals at the provincial level must be co-ordinated into a care system, the federal financial support should be organized to reflect this.

VII - PROVINCIAL MANIPULATION

At the present time, some provincial health programs can be funded under more than one federal conditional grant program. As an example, similar programs in hospitals for the mentally retarded can be supported by either the Vocational Rehabilitation of Disabled Persons Act or the Canadian Assistance Plan Act. What this can result in is that the provinces may expend considerable resources determining which program allows them to maximize the federal contribution to their province.¹ While this

¹This statement is based on the personal experience of the author while employed by the Department of Public Health in Saskatchewan and the Department of Health and Social Development in Alberta.

is an unnecessary use of resources at the provincial level, it also results in an inequitable distribution of federal expenditure among provinces.¹

Also, some provinces are more aware than others as to the financial benefits that can be derived from these programs, and ensure that they retain personnel to take advantage of the federal funding. Other provinces may not even be aware of the programs, or, if they are aware of the potential federal funding, may receive a more limited federal contribution because of their method or technique of requesting assistance.

VIII - SUMMARY AND OBSERVATIONS

The foregoing Chapter discussed a number of problems associated with conditional health grant funding.

The constitutional issue was described as a disagreement over the interpretation of the B.N.A. Act. Although opinions on this issue abound, it was concluded that any resolution to this issue could only come through the courts. Although some provinces have threatened this action, at the present time it seems that the issue will be left to negotiations between the two levels of government.

¹An example of this is the fact that, to the author's knowledge, only the provinces of Alberta and Saskatchewan cost-share the expenditures of their mental hospitals through the Vocational Rehabilitation of Disabled Persons Agreement. The remainder of the provinces do not receive federal funding for these types of programs.

The cost increases related to provincial health expenditures were documented and described as substantial. While the critics of conditional health grant funding noted the increases to conditional grants, it was pointed out that there is a problem in determining to what extent conditional funding was responsible. In this regard, it was pointed out that the United States, which has not been affected by major conditional grant problems for hospital and medical care has experienced the same relative increase in expenditures.

The problem associated with conditional health grant funding and its effect on provincial expenditure priorities was also discussed. It was concluded that any conditional grant had an effect on the provinces priorities but that this must be balanced against the federal argument that the purpose of the funding is to stimulate provincial expenditure.

The possible negative incentive effect of federal reimbursement under the Medical Care Act was described. While this is obviously not a major problem, it was concluded that it could be thwarting the federal purpose in the lower income provinces.

The lack of co-ordination among the Acts and the programs they support at both the federal and provincial level was also described as a problem. It was concluded that any system of federal financial support

should be organized and administered in a manner that contributes to co-ordination and integration of health care programs at the provincial level.

The last problem discussed was that related to provincial manipulation. It was concluded that this problem was an undesirable aspect of some of the current programs.

The discussion in the Chapter indicates that most of the problems related to the current conditional grant programs are related to the design and not the method. One problem that is not of this nature is the constitutional issue. But, given the current state of affairs, it does not seem reasonable to discontinue conditional health grant funding for this reason. Of course the fedreal government should attempt to minimize the problems, but until the issue is ruled on by the courts it would seem to be a generally accepted method of public finance in Canada.

The second problem that is definitely related to the method of conditional health grant funding is that of provincial priority distortion. This problem would seem to be more critical in the provinces with lower tax bases, but to a degree could affect all provinces in a detrimental fashion. Thus, it is obvious that any cost-shared conditional grant funding should be examined critically to ensure that other provincial expenditures that

may be as beneficial as health care expenditures are not neglected.

CHAPTER 6

STUDIES RELATED TO FEDERAL INVOLVEMENT IN FINANCING PROVINCIAL HEALTH PROGRAMS

I - INTRODUCTION

Over the years, there have been a number of studies and publications that have discussed the general applicability of federal conditional grant funding in Canada. The purpose of this Chapter is to briefly present the conclusions that were arrived at in these studies. It is of note that some of the earlier studies did not deal with conditional health grant funding per se, but they are included because of their general applicability to this field.

II - MAXWELL STUDY

The first comprehensive study of federal-provincial financial relations in Canada was J.A. Maxwell's Federal Subsidies to the Provincial Governments in Canada.¹ Part II of his book dealt specifically with conditional grant arrangements.² The only specific reference to conditional health grants was the existing venereal disease grant, and Maxwell saw this as being particularly successful.

¹J.A. Maxwell, Federal Subsidies to the Provincial Governments in Canada (Cambridge: Harvard University Press, 1937).

²Ibid., pp. 199-276.

"It would seem that for this expenditure . . . the federal government gained excellent results. The grant was begun at a time when public interest in this and related questions of public interest was at its height. The provinces were ready to follow a lead. Undoubtedly, many of them would have developed agencies for combatting venereal disease without federal aid; but some would have lagged. Besides, a co-ordinated plan was of considerable value."¹

Although Maxwell recognized some of the problems associated with conditional health funding, there does not seem to be much doubt that he saw it as being generally applicable to various types of programs, including health. Thus, he wrote in the last paragraph of his book:

"The device of conditional subsidies is peculiarly appropriate to the needs of federal countries. In such countries a constitutional division of functions between the provinces . . . and the federal government is unavoidable, but any given division will fail to meet the requirements of a changing world. Yet reapportionment of functions cannot be prompt because constitutional alteration must necessarily be slow. The wisest way to meet many of the difficulties which arise is to supplement the financial resources of the governments which are in need. If, for example, the provincial governments have a plethora of functions and a paucity of financial resources, the grant of conditional subsidies will provide a safe and effective remedy for the immediate difficulties and may point the way to a more enduring solution. That this scheme may be criticized as circuitous must be admitted. But some circuitousness is inevitable in federalism."²

¹Ibid., p. 226.

²Ibid., pp. 255-256.

III - GETTYS STUDY

L. Gettys' study entitled The Administration of Canadian Conditional Grants was essentially a study of the administrative aspects of the conditional grants existing in 1938.¹ In this study, Gettys does not directly comment on the desirability of this type of fiscal transfer mechanism, but deals with the administrative aspects of the programs.² Her conclusion was that the federal supervision of the programs was basically inadequate, and she related this to a lack of federal government commitment to interfere with provincial autonomy. Thus, while Gettys' study is interesting as a description of the administration of conditional grants in Canada, its usefulness insofar as determining whether federal conditional grants should be used as a fiscal transfer mechanism in Canada is limited.

IV - ROWELL-SIROIS REPORT

The 1940 Report of the Royal Commission on Dominion-Provincial Relations³ was a comprehensive

¹L. Gettys, The Administration of Canadian Conditional Grants (Chicago: Public Administration Service, 1938).

²Gettys alludes to the potentialities of conditional grant funding, but does not make explicit what these potentialities consist of. Ibid., p. 182.

³Canada. Report of the Royal Commission on Dominion-Provincial Relations, Book II (Ottawa, 1940).

examination of the Canadian federal system. The recommendations in the report regarding federal-provincial fiscal relations were that both levels of government in Canada should have mutually exclusive legislative responsibilities and sufficient revenue sources to carry out these responsibilities.¹ Thus, the Commission allowed little leeway for conditional grants and saw them as being useful only where the amounts of money involved were small and where the specific programs were subject to objective criteria.² In indicating how strongly the Commission felt about conditional subsidies, they wrote the following:

"Experiments were made with the conditional subsidy technique. It first seemed to be a happy compromise, and an escape from the straight jacket of obsolete statutory formulae. Assistance could be given where necessary, and administration left in provincial hands However, the flaws in the system became clearly apparent when, under the pressure of expanding social service demands and depression conditions in the thirties, the transfer grew to huge proportions. A system which might work well, even in a federation, on a limited scale and for certain specific and clearly defined functions, broke down completely as a means of financing a large portion of provincial functions The Dominion in respect to conditional subsidies had to impose either such rigid and detailed conditions (often unsuitable to local conditions), involving such minute inspection and regulation as to be a major infringement on provincial autonomy Even limited efforts at effective regulation of the expenditure of conditional subsidies led to bitter Dominion-provincial fights. But acceptance by the Dominion of the role of a rubber stamp opened the way to waste of public funds, incapacity to deal with national problems on a national scale and lack

¹Ibid., pp. 125-128.

²Ibid., p. 127.

of enforcement of national standards where these were appropriate."¹

V - SMILEY STUDY

Smiley's study entitled Conditional Grants and Canadian Federalism² was essentially a recapitulation of the spirit of the Rowell-Sirois Report, and thus conditional funding was relegated to a relatively minor role in federal-provincial financial relations. However, there were two circumstances where he felt that grants-in-aid were appropriate: (1) where the implementation of a necessary federal policy was dependent upon provincial action that would occur only with financial inducement; and (2) when residence requirements of either a provincial or local nature interfered with citizens' access to health and welfare services.³

Smiley then listed four criteria that were essential in making a success of any necessary conditional grant program.⁴ These were:

1. the program must be developed and planned in

¹Ibid., pp. 126-127.

²D.V. Smiley, Conditional Grants and Canadian Federalism (Toronto: Canadian Tax Foundation, 1963).

³Ibid., p. 61.

⁴Ibid., pp. 65-67. It is of note that Smiley developed these criteria on the basis of the success of the program authorized by the Hospital Insurance and Diagnostic Services Act.

consultation with the provinces and that this development and planning phase must cover a relatively long period of time;

2. the federal government must make a long-term commitment to support the programs and that they cannot be unilaterally terminated on short notice;
3. the federal government must provide a wide range of consultation and specialized advisory services in relation to the program; and,
4. the arrangements must provide a very wide range of provincial autonomy and that federal initiatives to influence the quality of the program should avoid explicit regulation.

VI - ROYAL COMMISSION ON HEALTH SERVICES

The Royal Commission on Health Services specifically recommended federal conditional grant participation in provincial health programs.¹ It recognized the benefits of the existing Hospital Insurance and Diagnostic Services Act and recommended federal participation in supporting a program of personal health services (medical care). The specific financial participation recommended by the Commission was:

¹Canada. Royal Commission on Health Services (Ottawa: Queen's Printer, 1964).

1. a grant of 50 percent of the actual program costs;
2. a limited grant to support the administrative costs of the program; and
3. a fiscal need grant for provinces with lower than average fiscal capacities.¹

The Commission also recommended the use of conditional health grant funding for other purposes. Specifically, it suggested that:

1. the general public health grant should be continued and the per capita amount increased;
2. the professional training grant should be continued and increased;
3. a dental health grant for children be introduced; and,
4. the grants for individual diseases be discontinued in provinces as their program for insured medical services became operative.²

While the Commission supported conditional health grant funding and believed that this method was the most effective and practical means of initiating new programs in the health field, it also anticipated a diminution of

¹Ibid., p. 84.

²Ibid., pp. 90-91.

the role of this type of funding.

"However, we can visualize a time when the comprehensive and universal health care programme which we have recommended has been adopted by all provinces and has been in operation for a number of years, thus demonstrating its viability and its full endorsement by the people of Canada.

When that stage has been reached, and if a province so requests, consideration should be given to a method of financing whereby the Federal government would vacate such a portion of tax fields as would yield revenues to a province corresponding to what it was receiving in federal grants, provided that the province in question would undertake in the future the programme on the broad basis then established, and continue to participate with the Federal government and other provinces in the planning and integration of health services for all Canadians."¹

VII - TASK FORCE REPORTS

The Task Force Reports on the Cost of Health Care in Canada were an attempt to enquire into and recommend on ways of restraining the rate of increase in health services expenditures in Canada.² Although the Task Force examined a number of aspects of health care, they did not discuss the role of federal conditional grant funding in any detail. But, while this was the case, there were a number of references in the text that seemed to indicate an acceptance of this form of federal support. Some examples of these references are:

¹Ibid., p. 87.

²Canada. Task Force Reports on the Cost of Health Care, Vol. 1 (Ottawa: Queen's Printer, 1969).

"That the Federal Hospital Insurance and Diagnostic Services Act be amended as necessary to include in-resident care classification levels,¹ 1 through 4 as insured services under the Act.

That the federal health grant structure be designed to co-ordinate the Public Health Research Grant and the National Health Grant in the field of medical care delivery and that the means and access² to these funds be clarified and publicized.

That programs of health centre construction be promoted in all provinces and that national health grants continue to be made available for this purpose."³

VIII - CARTER STUDY

Carter's study, Canadian Conditional Grants Since World War II, was a general but thorough study of conditional grants up to 1969.⁴ Carter attempted to support the use of conditional grants on the basis of economic theory;⁵ and while he recognized that some of the conditional grants had been defective in both design

¹Ibid., p. 127.

²Ibid., p. 141.

³Ibid., p. 168.

⁴G.E. Carter, Conditional Grants Since World War II (Toronto: Canadian Tax Foundation, 1971).

⁵Ibid., pp. 5-20. Carter specifically saw conditional grants as being a mechanism for the federal government to ensure optimal health expenditures at the provincial level.

and use, he strongly supported their continuation.¹ Although Carter did not specifically single out health grants as being particularly desirable, this was implied in his general examination and recommendations. It is of note that he specifically ruled out unconditional tax abatements and equalization payments as viable alternatives,² although he stated that more general block grants would appear to have some merit.³

IX - SUMMARY

This Chapter has reviewed a number of studies that relate to the applicability of conditional health grant funding. Although there is not a consensus of opinion on the value of conditional health grant funding, a number of studies supported this form of financial support. The major criticism of conditional funding that was presented in the reports was its infringement on political autonomy. The major arguments in support of conditional health funding were:

1. that it was a useful mechanism to overcome the imbalance of program responsibility and revenue

¹Ibid., p. 110.

²Ibid., p. 110.

³Ibid., p. 107.

sources that exist in relation to health as well as other programs;

2. that it was a useful device to stimulate needed universal health programs in all provinces; and,
3. that it allowed the federal government to attempt to ensure an optimal health expenditure pattern in Canada.

It is of note that only the Smiley study dealt in any detail with specific recommendations related to making a success of necessary conditional grant programs. Essentially he highlighted the need for:

1. long term consultation with the provinces in the planning and development of any program;
2. a long term commitment on the part of the federal government;
3. the federal government to develop and maintain consultation and specialized advisory services in relation to the program; and,
4. allowing the provinces as much autonomy as possible, while maintaining the federal purpose.

It seems rather obvious that if the federal government wishes to have successful shared-cost programs in any field, it would be desirable to follow the recommendations of the Smiley study.

CHAPTER 7

ALTERNATIVE FISCAL TRANSFER MECHANISMS

I - INTRODUCTION

The purpose of this Chapter is twofold. First, it will examine techniques other than conditional grants that would allow the provinces increased revenues to support their health programs. The specific mechanisms that will be examined are unconditional equalization payments, tax abatements, and block grants. This section will conclude with general observations as to the most appropriate fiscal transfer mechanism.

The second purpose of this Chapter is to examine the most recent proposals regarding federal financial assistance in support of provincial health programs. This section will conclude with comments as to the appropriateness of the proposals.

II - METHODS OF FISCAL TRANSFER

A. Unconditional Equalization

Canada has extensively used the technique of unconditional equalization payments as a mechanism for supplementing the revenues of lower-income provinces.¹

¹For a good description of Canadian federal-provincial financial relations, see J.C. Strick, Canadian Public Finance (Toronto: Holt, Rinehart and Winston of Canada, Limited, 1973), pp. 94-127.

Although the formula for equalization payments has varied over the years, the basic concept has consisted of transferring an unconditional grant to lower-income provinces that would bring the per capita yield from certain taxes up to a standard.¹ At the present time, nineteen taxes are used to bring the average per capita yield from these taxes up to the national average.²

Although the extension of unconditional equalization payments to support provincial health programs has the merit of recognizing provincial autonomy in a field where the provinces have legislative jurisdiction, the technique has a number of negative aspects. These are:

1. that the use of unconditional equalization payments doesn't recognize the potential external benefits of health expenditure at the provincial level, and thus the provincial allocation for health expenditures could be expected to be sub-optimal from the national point of view;
2. that the use of unconditional equalization payments would have an effect on the lower-income provinces only;

¹Ibid., pp. 104-105. The standard was initially the average yield of the two wealthiest provinces.

²Ibid., p. 115.

3. that the use of unconditional equalization does not recognize the social or political rationale in support of federal influence over provincial health programs;
4. that in Canada, unconditional equalization payments are in existence to counteract regional disparities, and additional equalization could be seen as redundant;¹ and
5. the unconditional funding could result in undesirable inter-provincial disparities in provincial health programs.²

The one major advantage of an unconditional equalization payment is the fact that the two most expensive health care programs would no longer be financed in an open-ended manner. But, while this is a potential advantage, it is not sufficient to counteract the disadvantages. This is particularly so when the advantages of a closed-ended funding system can be obtained under any method of financing.

B. Tax Abatements

Contracting out³ refers to the situation where

¹G.E. Carter, Conditional Grants Since World War II, p. 19.

²Ibid., p. 109.

³This is sometimes referred to as opting out.

a conditional grant program exists, but the province has the discretion to opt for a tax abatement in lieu of the conditional grant payment.¹ Theoretically, once a province has contracted out, the payment to that province is merely an unconditional grant equal to the value of the agreed upon tax abatement.

In Canada a variant of theoretical contracting out was devised that was, in essence, an equalized open-ended grant. As an example, a 1964 proposal specified that:²

1. any province that contracted out had to maintain program standards similar to those in effect under the conditional grant arrangement;
2. a personal income tax abatement of 14 points for hospital insurance and 1 point for public health grants be made to the opting out province.³ In addition, an equalization payment would be made to those provinces that received below the average per capita yield of this tax in the highest yield province; and

¹Contracting out is described in J.C. Strick, Canadian Public Finance, pp. 108-111.

²J.C. Strick, Canadian Public Finance, pp. 94-127.

³This would be based on the personal income tax from an individual province.

3. opting out provinces would neither gain nor lose financially, as federal payments would be adjusted to actual operating costs.¹

In 1966 the federal government revised its proposal for contracting out. The major differences in this proposal were that:

1. beginning in fiscal year 1970, federal payments would no longer depend on program costs, but would be based on an objective formula to be determined later;² and
2. the conditional grants would be discontinued.³

At the federal-provincial discussions over this proposal concern was expressed over maintaining standards and portability of benefits in the health programs. This precipitated some conditions being attached to the proposal.⁴

¹G.E. Carter, Canadian Conditional Grants Since World War II, pp. 90-91. These points are also described in J.C. Strick, Canadian Public Finance, pp. 109-110.

²This objective formula was that the payments to the provinces could increase at 1.5 times the growth in personal income. G.E. Carter, *ibid.*, p. 94.

³*Ibid.*, pp. 93-94.

⁴The conditions were essentially provisions to maintain a degree of similarity between provincial programs and the continuation of federal government technical assistance.

The eventual outcome of the proposal was that it was rejected by the provinces and was subsequently withdrawn by the federal government in 1969.¹

The benefits to be derived from either of the foregoing proposals are difficult to determine. The 1964 contracting out proposal was not really contracting out in the real sense of the term but was only a thinly guised conditional grant. Quebec accepted the 1964 arrangement and thus must have gained some satisfaction from the superficial autonomy; but, as the 1966 proposals were never accepted, real provincial autonomy was never achieved. One benefit of the 1966 proposal was that open-ended federal funding would be discontinued; but, as has been mentioned, this could be achieved with any method of funding.

C. Block Grants

Block grants have been described in the literature as possible alternatives to the existing conditional health grants.¹ Essentially, a block grant refers to a conditional

¹Ibid., p. 95

²Perhaps the best article on block grants in Canada is D.V. Smiley, "Federal Block Grants to the Provinces: A Realistic Alternative," in Report of the Proceedings of the Annual Tax Conference (Toronto: Canadian Tax Foundation, 1964), pp. 218-222.

fiscal transfer to the provinces for broadly defined purposes.¹ It is of note that the Royal Commission on Health Services specifically recommended consolidation of some of the health grants.²

The use of block grants for health funding in Canada would have a number of advantages.³

1. They would allow a degree of provincial autonomy, while at the same time ensuring that funds are generally expended in areas that can be justified from a national point of view;
2. They would simplify the administrative detail that is currently required under the existing conditional grant programs;
3. They would lend themselves easily to built-in expenditure constraints;
4. They would allow flexibility within individual grants for the province to pursue cost-saving techniques;
5. They would contribute to a lowered degree of acrimony between the federal and provincial

¹Ibid., p. 218.

²Canada. Royal Commission on Health Services, pp. 89-91.

³The advantages of block grants listed are not particularly discussed in detail in the literature, but are the author's opinions.

officials because of the greater discretion available at the provincial level.

Some of the disadvantages related to block grants are:

1. They would restrict the federal government from pursuing precise objectives on a specific program, and thus there is a risk that its economic, social and political objectives may not be achieved;¹ and,
2. They would make it difficult to determine the level of economic support that could be justified by the federal government unless programs with similar external benefits were grouped together.

D. Summation

This section has examined three alternative mechanisms that the federal government could use to supplement provincial revenues and, in turn, support health programs. It has shown that both an extension of equalization payments and tax abatements would contribute to more provincial autonomy; but, it was argued that both methods were inappropriate mechanisms for funding provincial health programs. As an alternative to the current conditional

¹D.V. Smiley, "Federal Block Grants to the Provinces", p. 220.

health grants, block grants were also examined. It was shown that, while this form of fiscal transfer has some advantages that the current programs do not have, this mechanism also has some disadvantages.

Thus, it appears that if the problems discussed in Chapter 5 are to be resolved in a manner that supports the rationale of federal financial involvement, a type of conditional grant must be utilized. This type of funding mechanism will exacerbate the constitutional problems associated with federal involvement; but, at the same time, it is the only method that will allow the federal government to legitimately pursue its objectives. Also, conditional grant funding in itself will not alleviate the problems examined in Chapter 5. The only avenue open to resolve these problems is the judicious design and administration of conditional grant programs.

III - RECENT FEDERAL PROPOSALS

The recent federal proposal is the result of a round of federal-provincial negotiations that commenced in 1970. It was initiated by the Federal Minister of Health as a direct result of the increasing federal financing responsibility incurred under the Medical Care Act and the

¹News Release. Department of National Health and Welfare, "Proposed New Arrangements for Financing Health Care in Canada", May 8, 1973, p. 1.

Hospital Insurance and Diagnostic Services Act. The federal orientation to the conference was:

" . . . that the objective of a new financing agreement should be to encourage a rational, efficient and flexible reorganization of the health care delivery system. The federal government would no longer relate its payments for health services to a share of provincial expenses in a range of high cost health care services. A new approach could enable the provinces to achieve flexibility in determining and pursuing their priorities within the context of national health standards of comprehensive benefits, accessibility to service, universal coverage, and portability of coverage between provinces."¹

The federal proposal contained the following provisions:

1. A federal per capita contribution to the provinces would replace existing financing arrangements for a five-year period beginning in 1974-1975;
2. The initial per capita contributions would be calculated in relation to the level of contributions paid under existing arrangements in 1972-1973;
3. The increase in per capita payments would be in proportion to GNP growth;

¹Ibid., p. 6.

4. There would be a leveling off of provincial per capita payments to a uniform national average over a ten-year period;
5. There would be no requirement that provinces maintain pre-existing ratios of health spending to federal contributions;
6. There would be additional federal payments to the provinces where provincial health spending grows much more rapidly than the growth in federal payments;
7. There would be a \$640 million trust fund to support cost saving measures that would be distributed on a per capita basis; and,
8. There would be a provision for negotiation of change in the agreement in 1979-1980.

At the present time, the proposal has not been accepted by the provinces, and its fate is unknown. But, as prime Minister Trudeau has subsequently referred to the proposal as the "final" proposal of the federal government, there is a possibility that the end result of the negotiations will be similar.¹ Thus, a review of its advantages and disadvantages is in order.

¹M. MacAskill, "Trends in Medical Service Markets Under Universal Health Insurance," (unpublished Masters Thesis, University of Alberta, 1974), p. 51.

The advantages of the proposal are difficult to determine. Originally the proposal was to have the major effects of reducing costs and introducing more flexibility at the provincial level. The inclusion of the provision that additional federal payments would be forthcoming should health spending grow much faster than the growth in federal payments would seem to negate the effectiveness of this cost constraint.¹ Also, the provinces would obviously have more flexibility under the proposal than under the current arrangements, but this comes completely at the expense of federal direction.² One other benefit of the proposal would be that, for programs without external benefits the provinces are in the best position to make resource allocation decisions.

The disadvantages of the proposal are not as difficult to assess. The major ones are as follows:

1. The emphasis in the proposal is on limiting the future federal financial liability for health funding, and thus there is not any attempt

¹Although the working of this provision is not precise, the commitment of the federal government to further expenditures over and above the GNP escalator at least puts any firm cost control in serious jeopardy.

²Chapters 2 and 4 of this thesis indicated that the federal government had a legitimate role in financing provincial health programs.

- by the federal government to rationally allocate resources;
2. In light of the provision that the proposal provides for additional federal payments if cost increases are substantial, it is not clear how future cost increases will be altered;
 3. The proposal could, and likely would, result in large inter-provincial disparities in both the types and quality of service provided;
 4. Under the proposal, it is difficult to see how the federal government could ensure even the minimal criteria of comprehensiveness, accessibility, universal coverage, and portability of service; and even if they could, if the programs varied greatly from province to province, the criteria would be meaningless;
 5. The national average per capita payments after the ten-year period could result in some provinces minimizing their health expenditures in a manner that would be detrimental to the citizens of the provinces and eventually to the economic well-being of the country as a whole;
 6. The proposal covers only two health grant programs; and,
 7. The proposal assumes an appropriate level in

financing health programs at the present time.

Thus, while a tremendous amount of effort has been expended on formulating the proposal, the end result is not particularly satisfactory. At the very least, the federal government is abdicating its role in the financing and influencing of health care for Canadians in its unsuccessful attempt to protect itself from future financial liability.

CHAPTER 8

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

I - INTRODUCTION

The purpose of this thesis was to examine the federal role in financing provincial health programs and to subsequently determine what this role should be in the future. To accomplish this objective, a number of aspects related to the federal role in financing provincial health programs were examined. The purpose of this final Chapter is to briefly summarize the contents of the thesis, draw conclusions that arise from and are relevant to the study, make recommendations regarding the future federal role in financing provincial health programs and suggest some practical steps that could be taken to minimize some of the current problems associated with the current conditional health grant programs.

II - SUMMARY AND CONCLUSIONS

The increasing state involvement in financing health care in Canada, and the financial problems this has posed, were outlined in Chapter 2. The specific problems discussed were:

1. The imbalance of expenditure responsibilities and revenue sources that exists between the federal and provincial governments in Canada;
2. The difficulty of provinces with a low tax base

supporting an equitable level of provincial services, including health care programs;

3. The difficulty in reconciling the national and provincial perspectives as to what health programs would be provided by the provinces.

In this Chapter it was noted that Canada has a relatively long history of federal involvement in financing and influencing health programs that are under provincial jurisdiction. Also, the federal government clearly sees the provision of certain provincial health care services as being in the national interest.

Chapter 3 examined the historical and current involvement of the federal government in financing provincial health care programs. The current federal involvement was elaborated under the programs authorized by the Hospital Insurance and Diagnostic Services Act, the Medical Care Act, the Health Resources Fund Act, the Canada Assistance Plan Act, and the Vocational Rehabilitation of Disabled Persons Act. A number of observations regarding the provincial health programs operated under the Acts were described. These were:

1. The most expensive federal programs (Medical Care and Hospital Insurance) are of an open-ended nature with no restrictions on the federal contribution other than that the expenditures must be authorized by the legislation and the

individual agreements signed between the federal and provincial governments. Some of the expenditures under the Canada Assistance Plan are also open-ended but do not contribute significantly to overall provincial health expenditures. All of the expenditures under the Vocational Rehabilitation of Disabled Persons Act are of a closed-ended nature as are some of the expenditures under the Canada Assistance Plan Act.

2. The major expenditures under the Acts are for labor and supplies, with only the Health Resources Fund supporting construction and the Hospital Insurance and Diagnostic Services Act providing support for some equipment.
3. The Vocational Rehabilitation of Disabled Persons Act is being used to support provincial expenditures on health care in a manner that is not equitable on an inter-provincial basis.
4. Some of the Acts are so obscurely worded that it is difficult to determine what can and cannot be cost-shared under them.
5. Some of the Acts overlap in the programs that they support in a manner that is not particularly logical or functional.
6. The funding under all of the Acts is clearly

related to health care, but some of the Acts are administered in relative isolation, and this contributes to undesirable fragmentation at both the federal and provincial levels.

7. The long term commitment of the federal government to participate in the programs supported under the Acts varies.
8. The mechanism for calculating the federal contributions under the Acts varies.
9. The major expenditures under the Acts are for acute care.
10. There is minimal emphasis in the Acts on cost control.

The rationale of federal involvement in financing provincial health programs was discussed in Chapter 4. Specifically, the economic, political and social arguments related to federal involvement were examined. While it is recognized that there were arguments against federal involvement related to all three of these areas, it was concluded that there was a legitimate rationale in support of federal participation. This Chapter made two further observations. The first observation was in relation to the type of fiscal transfer mechanism the federal government should utilize in its support of provincial health programs. In this regard it was concluded that the federal funding should be of a conditional nature, regardless of whether

the rationale in support of the funding was economic, political or social or a combination of the three. The second observation was in relation to the level of federal support that could be economically justified. On this point, it was concluded that as the economic rationale was supported on the concept of externalities, from an economic point of view, the federal support should be equal to the value of the external benefits.

Chapter 5 examined six major problems associated with the current conditional health grant programs. The problems discussed were those related to constitutional issues, cost escalation, provincial priority distortion, negative incentives, lack of co-ordination, and provincial manipulation. It was concluded that the majority of the problems were not an indictment of conditional grant funding per se, but were related to the design or the organizational administration of the existing programs. The one problem that was not covered by these two categories was that of provincial priority distortion. On this point, it was noted that wherever a grant is of a cost-share conditional nature, it will probably distort provincial priorities, and that this problem was most significant with the smaller, low-income provinces. It was concluded that, because of this difficulty, any cost-share conditional health grant program should be examined critically to ensure that provincial expenditure priorities

are not unduly influenced.

The conclusions of a number of studies related to federal financial involvement in financing provincial health programs were presented in Chapter 6. Although there was not a consensus of opinion as to the value of conditional health grant funding, a number of studies supported this form of transfer mechanism. The major criticism of conditional funding in the reports was its infringement on provincial autonomy. The major arguments in support of this type of funding were:

1. that it was a useful mechanism in overcoming the imbalance of program responsibilities and revenue sources that exists in relation to health as well as other programs;
2. that it was a useful device to stimulate needed universal health programs; and,
3. that it allowed the federal government to ensure an optimal health expenditure pattern in Canada.

Chapter 7 discussed transfer techniques other than conditional grants that would allow the provinces increased revenues to support their health programs. Two of the alternatives examined were unconditional equalization payments and tax abatements. It was noted that because these mechanisms allowed the provinces complete autonomy as to the health programs they would support, they were not acceptable. Block grants was another alternative

discussed. It was noted that although there were a number of advantages related to block grants, there were also a number of disadvantages, and thus the technique was not a panacea. Two specific disadvantages of block grants cited were:

1. they would restrict the federal government from pursuing precise objectives; and,
2. it would be difficult to calculate external benefits unless programs with similar externalities were grouped together.

The recent federal proposal regarding federal financial support of provincial health programs was also discussed in Chapter 7. It was concluded that while considerable effort had been expended in developing the proposal, the end result was not satisfactory, as it does not offer a solution to the cost escalation problem, while at the same time it introduces a number of problems not related to the current programs.

III - MAIN CONCLUSIONS

The main conclusion of this thesis is that the federal government has a legitimate role in financing and influencing health care programs that are under provincial jurisdiction. It is also concluded that the most appropriate fiscal transfer mechanism for the federal government to use in the fulfillment of this role is the shared-cost conditional grant.

Other subsidiary conclusions that arise from and are relevant to the study are:

1. There is a legitimate rationale in support of federal conditional health grant funding, and that this rationale is primarily economic, political and social;
2. For the federal government to carry out this legitimate role, it is necessary for it to infringe on the absolute autonomy of the provincial governments;
3. The current federal proposals are not an appropriate solution to the problems being encountered in the operation of the current conditional grant programs;
4. There are a number of serious problems associated with the current conditional grant programs, but the majority of these problems do not serve as an indictment of conditional health grant funding per se. They are more of an indictment of inappropriate design and organizational administration;
5. The one problem associated with conditional health grant funding that is not covered by the two foregoing categories is that of provincial priority distortion. This will always be a problem with cost-share conditional grants, and thus the ob-

- jective must be to ensure that provincial expenditure patterns are not unduly distorted;
6. One of the major goals of the federal government in fulfilling its role in financing provincial health programs should be that of absolute cost reduction or the minimization of the rate of increase in the cost of provincial health programs;
 7. The conditional health grant programs that are operated by the federal government should be administered in a manner that contributes to the integration and co-ordination of the funding programs at the federal and provincial levels.
 8. The funding should emphasize preventive approaches that deal with life style and self induced risks.
 9. The federal role in financing provincial health programs could consist of a combination of global block grants for health expenditures and specific grants-in-aid of particular programs that have definitive external benefits.

IV - RECOMMENDATIONS

1. The federal government should reconsider its latest proposal for financing provincial health programs and develop, in consultation with the

the provinces, a program that would allow it to fulfill its legitimate role in the financing of these programs. This review should be undertaken with the following considerations in mind:

- a) Any program that the federal government supports should have a clear justification supporting federal involvement, and this justification should be explicitly stated.
 - b) The programs should be designed to ensure that firm cost restraints are an integral aspect of the program.
 - c) The programs should be designed in consultation with the provinces to ensure that provincial dissatisfaction with the programs are minimized.
 - d) The programs should be designed to ensure that any individual province's expenditure patterns are not unduly distorted.
 - e) The program should be designed to ensure maximum provincial autonomy within the constraints of the federal government fulfilling its legitimate role.
2. The federal government should support research that would allow more knowledgeable and/or objective answers to the following questions:

- a) What provincial health programs are clearly in the national interest?
- b) What provincial health programs have external benefits, and what is the magnitude of these benefits?
- c) What is the most appropriate method of introducing, monitoring and revising programs that the federal government develops?
- d) What are the most appropriate mechanisms to induce cost restraint in the health care field, and how can the selected mechanisms be introduced as part of any federal conditional grant program?

V - RECOMMENDED PROPOSALS FOR FURTHER RESEARCH

This thesis has indicated that while there is an acceptable rationale in support of federal involvement in financing provincial health programs, there are a number of problems associated with the current conditional health grants. It is the contention of this thesis that the only successful, long run solution to the problems that have been discussed, is the pursuing of the recommendations that have been made.

However, from a practical point of view the usefulness of the recommendations may be questioned as it appears that decisions will be made before answers to the proposed

research is available. Thus, the following are suggestions for change in the current conditional health grant programs.¹ They are presented with the full realization that they are not ideal solutions, although they may represent an improvement over the current federal initiatives. Perhaps the only manner in which they can be defended is on the basis of reasonableness, in that they may allow some of the current problems to be resolved. It is of note that the proposals are not presented for definitive action by the federal government. At the very least, research has to be directed at any of the proposals to ensure its effectiveness.

Proposal #1

Develop an all inclusive Residential Care and Diagnostic Service Act. This would include the discontinuation of the Hospital Insurance and Diagnostic Services Act and those aspects of the Canada Assistance Plan and the Vocational Rehabilitation of Disabled Persons Act that relate to institutional care. The new Act would incorporate in conjunction with diagnostic service appropriate to the

¹The practicability of some of the proposals may still be questioned in that they require some form of federal-provincial agreement and agreement at this level is difficult to predict.

level of care, the following levels:¹

- a) acute treatment;
- b) specialty hospitals;
- c) rehabilitation hospital programs;
- d) extended care hospital programs;
- e) nursing home programs;
- f) day hospital programs;
- g) home care programs.

The benefits of this proposal are:

- a) it would reflect the continuum of care;
and,
- b) it relates diagnostic procedures to the
appropriate level of care.

Proposal #2

Finance residential care and diagnostic procedures in a manner that reinforces the use of the least cost program. This could be accomplished by the federal government funding a higher percentage of costs in the least cost programs. An example of financial reinforcement to use the least cost level of care is as follows:²

¹This list is for illustrative purposes only.

²It is of note that a similar technique could be used for the federal government to influence expenditures according to its priorities.

<u>Level of Care</u>	<u>% of Federal Contributions</u>
Acute Treatment	41
Specialty Hospitals	44
Rehabilitation Hospitals	47
Extended Care Hospitals	50
Nursing Homes	53
Day Hospitals	56
Home Care	59

The benefit of this proposal is that there is a financial benefit for the provinces to reverse the trend to care in higher cost residential facilities. Also, the federal government could use this technique according to its priorities.

Proposal #3

Develop a Health Professionals Reimbursement Act.

This would include revising the current Medical Care Act to reimburse private practice professionals other than physicians for rendering appropriate services. Although the types of services included for reimbursement by other professionals would have to be enumerated, the professional groups that should be considered are nurses, optometrists, psychologists and social workers. The benefits of this proposal are: it would allow persons to seek services from appropriately trained individuals, and it would allow lower cost manpower to provide services they are trained for.

Proposal #4

Introduce a ceiling on federal government participation in funding all provincial health programs equal to the total funding in fiscal 1975 plus factor equal to the percentage rise in GNP in succeeding years. This proposal would necessitate revisions in the total funding of all programs if the total funding exceeded the pre-determined amount (see Appendix 3 for an example of how this could theoretically work).

The benefit of this proposal is that it makes health grant funding closed-ended on a macro basis, and thus the total federal participation is predictable. This would in turn pass on an incentive to the provinces to carefully monitor increases in health costs, as they would have to pay one hundred percent of incurred costs over the pre-determined maximum. One result of a closed-ended grant system could be the provinces taking a much more rigorous look at how they influence cost reduction in health care programs.

Proposal #5

Introduce funding for innovative projects in health care delivery that is designed to provide service of a similar quality but at reduced cost.

The benefit of this proposal is that up to the present time there has really not been an adequate incentive

for researchers, health care planners or administrators to pursue methods of cost reduction in the delivery system. If funding for well thought out proposals was available there is every likelihood it would produce results that could then be applied on a more general basis.

Proposal #6

Introduce funding for professional remuneration based on a proportion of provincial per capita costs incurred as opposed to just a percentage of national per capita costs.

The benefit of this proposal is that it does not contribute to an incentive for provinces to unduly reduce their costs nor does it induce a province to overexpend, as a mechanism based only on the per capita costs of an individual province would.

Proposal #7

Introduce a mechanism for reimbursing the four lower income provinces up to an additional ten percent of their health care costs if they can produce evidence that health care expenditures are distorting their expenditure pattern in a significant manner.

The benefit of this proposal is that it allows an avenue of recourse to the provinces most likely to be adversely affected by health care expenditures.

VI - CONCLUDING COMMENTS

This thesis has attempted to examine the federal government's role in the funding of provincial health programs. It was concluded that the federal government had a legitimate role in financing provincial health programs and that this role could only be operationalized by the use of conditional grants. There are obviously many difficulties that must be faced if these conclusions are accepted. The author is aware of these difficulties but does not believe that they negate the validity of the outcome of the study. In the short-run, it may appear expedient for the federal government to allow the provinces complete autonomy in the provision of health services. This course of action does not consider the practicalities of public finance in a federal state, nor does it recognize the rationale in support of federal involvement. Thus, it would seem that the more reasonable approach consists of recognizing that, although there are difficulties associated with conditional funding, there are also benefits that accrue to the country as a whole. Walter Heller described these benefits rather succinctly when he wrote:

"They (conditional grants) unite federal financing with state-local performance in a fiscal marriage of convenience, necessity and opportunity: convenience because they enable the federal government to single out and support those state and local services in which there is an identifiable national interest . . . necessity because without this financial support the states and municipalities would be unable to meet the demands on them for

essential services . . . opportunity because putting the grants in conditional form enables the Federal government to apply national minimum standards, ensure financial participation at the state and local levels through matching requirements."¹

¹W.W. Heller, New Dimensions of Political Economy (New York: W.W. Norton, 1967), p. 141.

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APPENDIX 1

VI. DISTRIBUTION OF LEGISLATIVE POWERS

Powers of the Parliament

91 It shall be lawful for the Queen, by and with the Advice and Consent of the Senate and House of Commons, to make laws for the Peace, Order and good Government of Canada, in relation to all Matters not coming within the Classes of Subjects by the Act assigned exclusively to the Legislatures of the Provinces; and for greater Certainty, but not so as to restrict the Generality of the foregoing Terms of this Section, it is hereby declared that (notwithstanding anything in this Act) the exclusive Legislative Authority of the Parliament of Canada extends to all Matters coming within the Classes of Subjects next herein-after enumerated; that is to say, --

1. The amendment from time to time of the Constitution of Canada, except as regards matters coming within the classes of subjects by this Act assigned exclusively to the Legislatures of the provinces, or as regards right or privileges by this or any other Constitutional Act granted or secured to the Legislature or the Government of a province, or to any class of persons with respect to schools or as regards the use of the English or the French language or as regards the requirements that there shall be a session of the Parliament of Canada at least once each year, and that no House of Commons shall continue for more than five years from the day of the return of the Writs for choosing the House; provided, however, that a House of Commons may in time of real or apprehended war, invasion or insurrection

be continued by the Parliament of Canada if such continuation is not opposed by the votes of more than one-third of the members of such House.

- 1a. The Public Debt and Property.
2. The Regulation of Trade and Commerce.
- 2a. Unemployment insurance.
3. The raising of Money by any Mode or System of Taxation.
4. The borrowing of Money on the Public Credit.
5. Postal Service.
6. The Census and Statistics.
7. Militia, Military and Naval Service, and Defence.
8. The fixing of and providing of the Salaries and Allowances of Civil and other Offices of the Government of Canada.
9. Beacons, Buoys, Lighthouses and Sable Island.
10. Navigation and Shipping.
11. Quarantine and the Establishment and Maintenance of Marine Hospitals.
12. Sea Coast and Inland Fisheries.
13. Ferries between a Province and any British or Foreign Country or between Two Provinces.
14. Currency and Coinage.
15. Banking, Incorporation of Banks, and the Issue of Paper Money.
16. Savings Banks.
17. Weights and Measures.
18. Bills of Exchange and Promissory Notes.

19. Interest.
20. Legal Tender.
21. Bankruptcy and Insolvency.
22. Patents of Invention and Discovery.
23. Copyrights.
24. Indians, and Lands reserved for the Indians.
25. Naturalization and Aliens.
26. Marriage and Divorce.
27. The Criminal Law, except the Constitution of Courts of Criminal Jurisdiction, but including the Procedure in Criminal Matters.
28. The Establishment, Maintenance, and Management of Penitentiaries.
29. Such Classes of Subjects as are expressly excepted in the Enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces.

And any Matter coming within any of the Classes of Subjects enumerated in this Section shall not be deemed to come within the Class of Matters of a local or private Nature comprised in the Enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces.

92 In Each Province the Legislature may exclusively make Laws in relation to Matters coming within the Classes of Subject next herein-after enumerated; that is to say, --

1. The Amendment from Time to Time, notwithstanding anything in this Act, of the Constitution of the Province, except as regards the Office of Lieutenant Governor.
2. Direct Taxation within the Province in order to the raising of a Revenue for Provincial Purposes.

3. The borrowing of Money on the sole Credit of the Province.
4. The Establishment and Tenure of Provincial Offices and the Appointment and Payment of Provincial Officers.
5. The Management and Sale of the Public Lands belonging to the Province and of the Timber and Wood thereon.
6. The Establishment, Maintenance, and Management of Public and Reformatory Prisons in and for the Province.
7. The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.
8. Municipal Institutions in the Province.
9. Shop, Saloon, Tavern, Auctioneer, and other Licences in order to the raising of a Revenue for Provincial, Local, or Municipal Purposes.
10. Local Works and Undertakings other than such as are of the following Classes:
 - a) Lines of Steam or other Ships, Railways, Canals, Telegraphs, and other Works and Undertakings connecting the Province with any other or others of the Provinces, or extending beyond the Limits of the Province;
 - b) Lines of Steam Ships between the Province and any British or Foreign Country;
 - c) Such Works as, although wholly situate within the Province, are before or after their Execution declared by the Parliament of Canada to be for the general Advantage of Canada or for the Advantage of Two or more of the Provinces.
11. The Incorporation of Companies with Provincial Objects.
12. The Solemnization of Marriage in the Province.
13. Property and Civil Rights in the Province.
14. The Administration of Justice in the Province,

including the Constitution, Maintenance and Organization of Provincial Courts, both of Civil and of Criminal Jurisdiction, and including Procedure in Civil Matters in those Courts.

15. The Imposition of Punishment by Fine, Penalty, or Imprisonment for enforcing any Law of the Province made in relation to any Matter coming within any of the Classes of Subjects enumerated in this Section.
16. Generally all Matters of a merely local or private Nature in the Province.

APPENDIX 2

OUT-PATIENT SERVICES INSURED UNDER THE HOSPITAL INSURANCE AND DIAGNOSTIC SERVICES ACT

Newfoundland

- Laboratory and radiological procedures including radio-active isotopes, electroencephalograms, cardiograms and basal metabolism estimations together with the necessary interpretations.
- Use of radiotherapy facilities, including radio-active isotopes.
- Use of physiotherapy facilities.
- Day care services.
- Clinic and emergency visits, including use of operating rooms, application of casts, drugs, and medical and surgical supplies administered in hospital.

Prince Edward Island

- Laboratory, radiological and other diagnostic procedures including the use of radioactive isotopes.
- Drugs, biologicals and related preparations for emergency diagnosis and treatment.
- Use of physiotherapy services.
- Speech therapy services.
- Use of radiotherapy facilities.
- Use of operating rooms and anaesthetic facilities, including the necessary equipment and supplies.
- Routine surgical supplies.

Nova Scotia

- Laboratory, radiological and electroencephalographic examinations together with the necessary interpretations.
- Diagnostic procedures involving the use of radioactive isotopes.
- Radiotherapy services.
- Use of physiotherapy facilities.
- Minor medical and surgical procedures.
- Provision of blood including blood fractions.
- Diabetic day care clinic services.
- Haemodialysis.
- Pulmonary function tests and inhalation therapy.

- Electrocardiograms and untrasonic diagnostic procedures.
- Non-medical component (excluding drugs, biologicals and related preparations) of all diagnostic and treatment out-patient procedures (excluding dental procedures).

New Brunswick

- Laboratory and diagnostic radiological procedures.
- Physiotherapy services.
- Minor surgical procedures.
- Radiotherapy services.
- Electro-shock therapy.
- Basal metabolic rate.
- E.C.G. and E.E.G.

Quebec

- Minor surgical procedures, including necessary radiological and laboratory examinations.
- Psychiatric day care and night care.
- Electro-shock and insulin-shock therapy.
- Psychotherapy.
- Audiology and speech therapy.
- Medical orthoptics.
- Occupational therapy.
- Cytological examinations.
- Radiotherapy and physiotherapy services.
- All radiological diagnostic services including tests involving the use of radioactive isotopes and any other diagnostic test or procedure preformed upon medical prescription such as electroencephalograms, electrocardiograms, echoencephalograms, vectorcardiograms, phonocardiograms, and angiocardiograms.
- Ophthalmological diagnostic tests.

Ontario

- Radiotherapy, occupational therapy, physiotherapy, and speech therapy in specified hospitals.
- Hospital component of all other out-patient services, including the use of operating rooms and anaesthetic facilities and surgical supplies.

Manitoba

- Use of operating room and anaesthetic facilities including the necessary equipment and supplies.

- Physiotherapy, occupational therapy and speech therapy.
- Electro-shock therapy.
- Services provided by the Manitoba Cancer Treatment and Research Foundation.
- Psychiatric day care services.
- Services provided by the Pre-School Development Clinic administered by the Children's Hospital of Winnipeg.
- Laboratory, radiological and other diagnostic procedures.

Saskatchewan

- All radiological and laboratory procedures including electrocardiograms and electroencephalograms.
- All physiotherapy and occupational therapy services.
- Non-medical component of all other procedures carried out by a hospital in the course of providing diagnostic or treatment services.

Alberta

- All services normally provided by a hospital to in-patients, including radiotherapy and physiotherapy.
- Services provided by the provincial cancer clinics and the provincial laboratories.

British Columbia

- Rehabilitation day care services.
- Cancer therapy services.
- Cytology services.
- Specified day-care surgical services and minor surgery.
- Psychiatric out-patient services.
- Drug addiction.

Northwest Territories

- Laboratory, radiological and other diagnostic procedures including the necessary interpretations.
- Radiotherapy and physiotherapy.
- Use of operating rooms and anaesthetic facilities including necessary equipment and supplies.
- Drugs, biologicals and related preparations.
- Routine surgical supplies.

Yukon Territory

- Laboratory, radiological and other diagnostic procedures.
 - Use of operating rooms and anaesthetic facilities including necessary equipment and supplies.
 - Drugs, biologicals and related preparations.
 - Routine surgical supplies.
-

SOURCE: Canada. Annual Report Respecting Operations of the Hospital Insurance and Diagnostic Services Act (Ottawa: Department of National Health and Welfare, 1973), pp. 2-4.

APPENDIX 3

THEORETICAL EXAMPLE OF CLOSED-ENDED FEDERAL FUNDING

If one assumes that there are two health programs funded by the federal government then the federal participation in 1975 was \$1,000,000 calculated as follows:

	<u>Provincial Cost</u>	<u>% Federal Participation</u>	<u>Federal Cost</u>
Program A	\$1,000,000	60	\$ 600,000
Program B	<u>1,000,000</u>	40	<u>400,000</u>
Total	<u>\$2,000,000</u>		<u>\$1,000,000</u>

In 1976, if the rise in GNP is 10 percent then the allowable federal government contribution is \$1,100,000. But if the provincial expenditures rise to \$1,100,000 for Program A and \$1,300,000 for Program B the federal participation based on sharing 60% of Program A and 40% of Program B would be calculated as follows:

	<u>Provincial Cost</u>	<u>% Federal Participation</u>	<u>Federal Cost</u>
Program A	\$1,100,000	60	\$ 660,000
Program B	<u>1,300,000</u>	40	<u>520,000</u>
Total	<u>\$2,400,000</u>		<u>\$1,180,000</u>

But it has already been determined that the total federal participation for 1976 could only be \$1,100,000

and thus the province cannot claim the extra \$80,000. This would result in the province having to make up the \$80,000 from its own funds and further, it induces pressure on the provincial government to attempt to move expenditures into Program A where a higher percentage of costs are shared by the federal government.

If the federal government has already determined that Program A is the least cost method of providing care and the higher percentage of cost sharing is for this program it could result in the province developing more least cost programs.

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